Missouri

UNIFORM APPLICATION
FY 2008

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Missouri
DUNS Number: 780871430-

Uniform Application for FY 2008 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Missouri Department of Mental Health

Organizational Unit: Division of Alcohol and Drug Abuse

Mailing Address: 1706 E. Elm Street P.O. Box 687

City: Jefferson City Zip: 65102-0687

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Mark Stringer

Agency Name: Missouri Department of Mental Health Div. of Alcohol and Drug Abuse

Mailing Address: 1706 E. Elm Street P.O. Box 687

City: Jefferson City Zip Code: 65102-0687

Telephone: (573) 751-9499 FAX: (573) 751-7814

E-MAIL: mark.stringer@dmh.mo.gov

III. STATE EXPENDITURE PERIOD

From: 7/1/2005 To: 6/30/2006

IV. DATE SUBMITTED

Date: 9/27/2007 8:03:17 AM ☒ Original ☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Mark Stringer Telephone: (573) 751-9499

E-MAIL: mark.stringer@dmh.mo.gov FAX: (573) 751-7814

Form 2 (Table of Contents)

State:
Missouri

UNIFORM APPLICATION FOR FY 2008 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as Required by the Public Health Service (PHS) Act

The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
State: Missouri	
Name of Chief Executive Officer or Designee: Keith Schafer	
Signature of CEO or Designee:	
Title: Director	**Date Signed:**
If signed by a designee, a copy of the designation must be attached	

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION Department of Mental Health	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
☐ Prime ☐ Subawardee Tier _____ , if known: _____ **Congressional District**, *if known:* _____	 **Congressional District**, *if known:* _____
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** if known:	9. **Award Amount,** if known: $
10. **a. Name and Address of Lobbying Entity** *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

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Standard Form – LLL -A

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION Department of Mental Health	DATE SUBMITTED

State:
Missouri

FY 2005 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2005 is reflected on Line 8 of the Notice of Block Grant Award

$26,331,154

Missouri

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

During FY 2005, the Missouri Division of Alcohol and Drug Abuse (ADA) supported a strong continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are made available at locations throughout the state based on needs assessments and the availability of qualified care providers. Treatment and support services were delivered by 40 Primary Recovery programs, 2 contracted opioid programs and 51 Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. The number of CSTAR programs increased due to the transition of two opioid treatment programs to the CSTAR model in FY 2005.

Detoxification

Often the first step in recovery, detoxification services assist consumers in withdrawing from addictive substances in a safe, supportive, and closely monitored environment. At admission, trained staff assess a consumer's need for detoxification services utilizing physician-approved protocols. This assessment guides the individual's placement into an appropriate level of care given the consumer's physical and mental needs. The types of detoxification programs available in Missouri are medical, modified medical and social setting. During the course of detoxification, consumers are assisted in making arrangements for continuing treatment.

CSTAR

Developed by ADA and funded by Missouri's Medicaid program and ADA's Purchase of Service system, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program provides a continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. Available services include assessment, individual and group counseling, group education, community support, residential or housing support as appropriate, a trauma individual and group counseling, and family therapy. In addition, families can also participate in individual and group codependency counseling.

In FY 2005, there were three different types of CSTAR programs available in Missouri: women and children, adolescent, and general population. The women and children, adolescent, and general population CSTAR programs offer three graduated levels of care. The most intensive level offers a residential component for individuals needing that kind of structure and support. Consumers can enter the program at any level and move between levels depending on their assessed needs, problem severity and treatment progress.

CSTAR Women and Children's Treatment Programs

Substance (POS) abuse can affect women differently than men, both physically and psychologically. Specialized CSTAR programs are offered for women and their children with programming that is relevant to this population. Pregnant women and women with children in their care are the priority populations. The full array of services is available

and is tailored to the consumer's unique needs. In addition, daycare is provided to ensure childcare is not an obstacle to treatment. Alternative Care is a more specialized type of women and children's program that resulted from a joint effort through ADA and the Missouri Department of Corrections. Designed specifically for female offenders being released from correctional institutions and those under probationary supervision, there is one program in each of Missouri's two metro areas, St Louis and Kansas City.

CSTAR Adolescent Programs
Adolescent CSTAR programs offer a full continuum of services provided by specially trained staff to consumers 12 to 17 years of age. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Consumers in the residential programs are offered academic support services to minimize disruptions in their education to the degree possible.

CSTAR Population Programs
General CSTAR programs offer the complete array of substance abuse treatment and supportive services to men and women receiving Medicaid.

Opioid Treatment Programs
Opioid programs utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs while under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle. Missouri's opioid treatment programs comply with applicable federal guidelines. During FY 2005 two of the ADA contracted opioid programs were converted to the CSTAR model.

Primary Recovery and Primary Recovery Plus (PRT)
At the start of FY 2004, the primary recovery programs represented the general alternative to the multi-level, Medicaid-supported, CSTAR programs. Residential and outpatient treatment were the available program options and were largely uniform in their menu of services. In an effort to provide a more comprehensive array of community-based treatment services tailored to address the unique needs of consumers, seven primary recovery residential programs participated in a pilot project, converting their former two-tiered treatment model to one patterned after the CSTAR continuum of care model described above. During FY 2005, the remaining primary recovery programs were converted to the PRT model.

State regulations pertinent to substance abuse treatment and prevention can be found in the Code of State Regulations (CSR) 9 CSR 30-3 which was filed with the Missouri Secretary of State.

FY 2007 (Progress)

In FY 2007, the Division of Alcohol and Drug Abuse (ADA) continued to support and monitor a full continuum of substance abuse treatment services throughout the state of Missouri via contracts with private treatment providers. Treatment and support services were delivered by 40 Primary Recovery Plus programs and 48 Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs.

By the start of FY 2006, all primary recovery programs had been converted to the Primary Recovery Plus model under the Access to Recovery (ATR) grant that was awarded to Missouri in FY 2005. The goals of the grant are to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity. Recovery supports are intended to help keep consumers engaged in treatment for longer periods of time by addressing issues that may otherwise serve as barriers to treatment completion. As of May 2007, there were 107 different providers of recovery supports. A full menu of recovery support services is available which includes care coordination, work preparation and pastoral counseling.

The conversion of the primary treatment programs to an enhanced multi-level model resulted in key improvements to the overall system of care. First, the conversion requires that each treatment provider with whom ADA contracts must either provide a continuum of clinical services that are individualized to meet each consumer's assessed needs, or refer to a program that can provide this level of care option. Secondly, the conversion coincided with an expansion of the monitoring services provided through the Clinical Utilization Review Unit. This unit functions as a monitoring, consulting, and training unit within ADA to ensure the best consumer care is provided in an appropriate, efficient manner.

ADA has entered a partnership with ten contracted substance abuse treatment providers located throughout Missouri funded by a Robert Wood Johnson Foundation two year grant. The focus of the first project year is the development and implementation of medication-assisted services to treat alcohol dependence. The focus in the second year will be cognitive-behavioral therapy techniques used in the treatment of trauma symptoms. ADA has amended provider partner contracts to allow for the reimbursement of medication, physician, and laboratory services associated with the use of naltrexone or acamprosate. As research suggests, 60-80% of consumers entering substance abuse treatment present with trauma symptoms. Contracts have also been amended to allow an enhanced reimbursement rate for trauma-enhanced individual counseling and group education services.

The Division of ADA continues to collaborate with SAMHSA, CSAT, and other opioid accrediting bodies to evaluate certified opioid treatment programs. Discussion topics during conference calls include: current issues in opioid treatment; disaster planning;

methadone deaths; drug abuse patterns and trends; accreditation survey scope and practice and accreditation standards and guidelines.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to fund the established continuum of services described in the above sections, but will promote and support a wider utilization of evidenced-based practices by treatment providers.

ADA has entered a partnership with ten contracted substance abuse treatment providers throughout Missouri with a focus on the development and implementation of medication-assisted services to treat alcohol dependence, as well as, cognitive-behavioral therapy techniques used in the treatment of trauma symptoms. ADA has amended provider partner contracts to allow for the reimbursement of medication, physician, and laboratory services associated with the use of naltrexone or acamprosate. As research suggests, 60-80% of consumers entering substance abuse treatment present with trauma symptoms. Contracts have also been amended to allow an enhanced reimbursement rate for trauma-enhanced individual counseling and group education services.

ADA plans to pursue the establishment of Centers of Excellence for the comprehensive treatment and prevention of substance abuse disorders and compulsive gambling. In doing so, providers will embody the "13 Principles of Effective Treatment" developed by the National Institute on Drug Abuse. Prevention providers and coalitions will fully employ the Strategic Prevention Framework.

In order to move forward with this initiative, ADA will be defining Centers of Excellence by forming a steering committee comprised of consumers, providers, State and Regional Advisory Council members, Missouri Recovery Network, ACT Missouri, Southwest CAPT, Missouri Institute of Mental Health, Committed Caring Faith Communities, partnering state agencies, and other stakeholders. The steering committee will accomplish its work through a series of face-to-face meetings and conference calls. Work groups will also be formed to focus on specific areas such as services for adolescents, women, offenders and senior adults.

The Division of ADA will be continuing the collaboration with ten certified and contracted providers funded by a Robert Wood Johnson Foundation grant to increase the utilization of evidence-based practice. The focus of the partnership's second year activity will be increasing the use of cognitive behavioral therapy to treat trauma symptoms. The medication assisted treatment interventions that began in the first year of the partnership collaboration will be continued into the second year.

The Division of ADA will continue to collaborate with SAMHSA, CSAT, and other opioid accrediting bodies to evaluate certified opioid treatment programs. Discussion topics during conference calls will include: current issues in opioid treatment; disaster planning; methadone deaths; drug abuse patterns and trends; accreditation survey scope and practice and accreditation standards and guidelines.

Missouri

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal Selective and Indicated:

- Universal: Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
  - Universal Direct. Row 1—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)
  - Universal Indirect. Row 2—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices).This also could include interventions involving programs and policies implemented by coalitions.

- Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (Adapted from The Institute of Medicine Model of Prevention)

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) supported 11 Regional Support Centers in providing information on legislative updates, team leader meetings, grant and funding information, and conference and workshop information to over 200 community coalitions consisting of over 2,000 members. ADA's Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis provided current prevention information to prevention practitioners at the state and community levels. ADA's RADAR network targeted people who were ages 5-64, potentially reaching 4.4 million people. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network supported local communities by providing information to the coalitions about preventing teen alcohol, tobacco, and drug use.

Merchant education materials were developed annually and distributed to the Regional Support Centers (RSC) for dissemination during the annual tobacco merchant education campaign. The merchant education campaign included a phone call and three walk-in visits. During the campaign, the RSCs informed the merchants of the availability of additional technical assistance and employee training. Several support centers have partnered with the Division of Liquor Control and have provided training to vendors in their region.

Partners in Prevention (PIP) published a newsletter titled "Journeys". The newsletter was published quarterly and provides education and prevention messages to encourage the reduction in underage and binge drinking. A quarterly newsletter was distributed to over 200 people across the state affiliated with colleges and universities, local agencies, and community teams. A website targeting the public was created in FY 2004. Risk and Protective factors are utilized and examples of focus topics included alcohol, marijuana, underage drinking, suicide, and Fetal Alcohol Syndrome (FAS) Disorder.

Education

ADA participated in the Perinatal Substance Abuse Advisory Committee, a state wide interagency collaboration committed to ensuring the health and welfare of pregnant and postpartum women, children and their families. The Committee was instrumental in the identification of state and local substance abuse issues and resources, provided and promoted public and professional education, monitored compliance of RSMo 191 (Senate Bill 190), and fostered communication of stakeholders through active networking. Other state agencies involved were the Missouri Department of Health and Senior Services (DHSS), Missouri Department of Social Services, Division of Family Services, and the Missouri Department of Elementary and Secondary Education. The Committee held quarterly meetings through April 2005 when it was disbanded under budgetary constraint.

ADA partnered with DHSS in the FAS prevention grant funded by the Centers for Disease Control and Prevention. The grant's target area was identified as approximately two-thirds of the state, excluding the metropolitan areas of Kansas City and St. Louis. Seventy-one of the 115 counties comprise this area. Data from the 2000 census and DHSS indicate that this geographic area has at least 500,000 childbearing-age women, ages 12-44. FY 2005 was year two of the grant award.

ADA worked closely with the DHSS to build the capacity of Missouri's communities to decrease the age of initiation of youth tobacco use and to reduce adult use. ADA was an active member of the DHSS' Comprehensive Tobacco Use Prevention Steering Committee. The purpose of the steering committee was to build a strategic plan to develop effective statewide programs to reduce tobacco use initiation, increase cessation, reduce exposure to environmental tobacco smoke and reduce disparities.

ADA's 11 RSCs conducted statewide merchant education visits between the months of February and June 2005. The purpose of these visits was to provide information and education regarding the state's law on youth access to tobacco products. Each retailer received three walk-in visits. More than 20,000 contacts were completed.

The Missouri School-based Prevention and Intervention Initiative (SPIRIT) program provided contracted training for staff from the five sites to encourage their implementation of evidence based curriculum which included Peace Builders, Positive Action for Living, and Reconnecting Youth. Three trainings were provided in Jefferson City to the SPIRIT staff members during 2005.

Partners in Prevention (PIP) provided on-going training to 1,012 higher education professionals and college students through a state wide conference and monthly meetings during FY 2005.

Mobilization

The RSCs responded to the technical assistance needs of over 200 local teams, task forces and coalitions in developing the skills necessary for effective functioning. The support centers utilized a community assessment tool to survey their community coalitions in their service areas. This tool helped the teams to identify target areas, focus their work efforts, and enhance their community effectiveness. Services to diverse target populations were supported with technical assistance to enhance their capacity to support youth-based and culturally specific community groups such as deaf, Native American, and Hispanic coalitions.

Partners in Prevention (PIP) is a statewide coalition comprised of 12 Missouri universities across the state whose goal is to develop strategies for reducing and preventing high-risk drinking among Missouri's college students through partnerships with universities and local coalitions.

Under the direction of ADA, the Prevention Workforce Development Task Force continued studying Missouri's workforce. One of the key findings from a Workforce Survey administered by the Task Force was that prevention in Missouri needed to be professionalized. ADA utilized this review to identify the requirements for certified prevention professionals. The review resulted in identifying the topics for various education opportunities offered to train prevention professionals for certification. The Task Force continued to outline prevention domains specific to the needs of Missouri's prevention professionals.

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 16-18, 2007 with 1,126 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma informed care, best practices in community problem solving, and medication assisted treatment.

The Division of ADA provided training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders. The focus of the training included community assessments, capacity building, and measurable outcomes. ADA consistently collaborated with CSAP's Southwest Center for the Application of Prevention Technology to provide training and technical assistance to promote community development, accountability, and targeted prevention initiatives based on CSAP's best practice program recommendations. ADA supported the 18th annual National Prevention Network Prevention Research Conference held August 2005 in New York.

Alternatives

In addition to the support for local activities which promoted healthy alternatives to alcohol, tobacco, and other drug use, ADA supported outcomes measurement of results and the implementation of best practice prevention programs. Community coalitions provided alternative prevention activities to approximately 3,000 participants throughout the year as identified by their annual community team action plans. In FY 2004, a consultant bank provided training and technical assistance in specific areas to 40 teams to develop alternative activities and program development. Another resource for communities was provided through mini-grants. Approximately 60 awards ranging from $5,000 to $10,000 were distributed under the categories of capacity building, model programs, and community norms. The average award was $6,000. ADA utilized the U.S. Education Office of Safe and Drug Free Schools Governor's Discretionary funds for the mini-grants and consultant bank resources provided to community coalitions.

Alternative prevention activities such as community service and youth leadership projects were provided to approximately 500 college aged students of the 12 Missouri universities comprising the statewide PIP coalition.

Environmental (Social Policy)

"Alcohol: Is it Worth It?" was a comprehensive, broadcast media advertising campaign targeting urban and non-urban high school-aged youth, parents, and other adults. The campaign consisted of diverse themed ads in a campaign which consisted of television and radio public service messages. Three television public service announcements targeted teenage party-goers and a boys and girls campaign was aired on prime time television and radio to reach youth groups during popular shows including reality shows and on the Top 40 and Hot Country radio stations. This campaign ran during the spring of 2005 and utilized 15 television stations and 115 radio stations throughout the state. An estimated 4 million people were reached through the media campaign.

Partners in Prevention (PIP) encourages and nurtures collaboration among colleges and state agencies to develop strategies for reducing and preventing high-risk drinking among Missouri's college students and to create partnerships that will result in systemic environmental change.

Problem Identification and Referral

In the spring of 2005, the 12 PIP universities conducted the Core Institute Alcohol and Drug Survey. The survey was administered to a random sample of 5% of the student population reaching a total of 7,129 students. The 2005 Core survey results were similar to the 2004 results, with 64.3% of the Missouri college students reporting using alcohol before age 18, and 25.6% of students reporting regular use of alcohol in the past year. Survey results also indicate that 48.4% of students had engaged in binge drinking at least once in the past two weeks. This percentage is slightly lower than the 49.9% reported from the 2004 survey. An additional question was added to the Core survey, "How many times in the past two weeks have you had five or more drinks in a two-hour period?" Student response indicated that 39.6% did engage in this behavior at least once. This behavior will continue to be surveyed.

Children accompanying their mother's into specialized Women and Children Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs were provided age-appropriate, developmentally-based support services for children to break the cycle of inter-generation substance abuse. All contracted CSTAR treatment programs provided specialized services to women and their children to address therapeutic issues relevant to the children. Services were provided by qualified child development professionals who were knowledgeable about substance abuse prevention. Screenings were conducted for each child under age 12 whose mother was admitted for residential treatment for substance abuse. The mother's treatment record included documentation of their child's developmental, physical, emotional, social, educational, and family background and current status. When indicated with the screening, a qualified staff member completed an assessment to identify appropriate therapeutic services. The age-appropriate activities offered included training and guidance in building self-esteem; learning to identify and express feelings; building positive family relationships; developing decision making skills; understanding chemical dependency and its effects on the family; learning to practice nonviolent ways to resolve conflict; and learning safety practices to reduce sexual abuse. These activities were

provided to enhance the social and family functioning and to increase resiliency.

FY 2007 (Progress)

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) information dissemination strategy was implemented through multiple prevention providers including the three Regional Alcohol and Drug Awareness Resource (RADAR) network sites, 11 Regional Support Centers (RSC), the Statewide Resource Center, the University of Missouri sites, and community coalitions. Information was disseminated using broadcast media and potentially reached four million individuals aged 5 to 64 years. ADA continued to support resource network involvement in health and prevention fairs, parades, resource fairs, and numerous other community team events where information on alcohol, tobacco, and other drug (ATOD) use and abuse was disseminated to community members. National prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3-D Month, and Alcohol Awareness Month also provided opportunities for RSCs and community coalitions to disseminate information about ATOD to community members. Support Center staff continued to make presentations to area civic groups at the local community levels. The 154 community coalitions served as an ongoing venue to distribute information at the local level throughout the state. Information distributed included ADA fact sheets on alcohol, underage drinking, marijuana, women and alcohol, and methamphetamine.

Merchant education materials were developed yearly and distributed to the RSCs for dissemination during the annual tobacco merchant education campaign. A merchant training manual was developed and distributed to the RSCs. The manual focused on helping retailers with the comprehensive training of sales personnel. RSCs developed a training plan based on this document and during the campaign informed retailers of the availability of technical assistance and training for their employees. The merchant education campaign consists of a phone call and two walk-in visits to the retailers. Several support centers have partnered with the Division of Alcohol & Tobacco Control and have provided training to vendors in their region.

The Division of ADA's RADAR network sites located in Jefferson City, Kansas City, and St. Louis continued to provide current information to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network continued to support local communities by providing information to the coalitions about preventing teen ATOD use and interventions for high risk groups. Several RSCs published newsletters and produced websites that provided information to their community coalitions about capacity building and important facts about ATOD. They also showcased success stories which helped motivate communities with similar circumstances and problems.

The Division of ADA continued to contract with the University of Missouri-Columbia to support the Partners in Prevention (PIP) statewide coalition comprised of 12 Missouri public institutions of higher education. The PIP is co-funded by the Missouri Division of Highway Safety and encourages and nurtures collaboration among colleges and state

agencies to develop strategies for reducing and preventing high-risk drinking among Missouri's college students and to create partnerships that will result in systemic environmental change. Partners in Prevention (PIP) publishes a quarterly newsletter titled "Journeys" which is sent to over 200 people affiliated with colleges and universities, local agencies, and community teams.

Education

The Center for Substance Abuse Prevention (CSAP) Model Programs continued to be implemented through community-based contracts with Boys and Girls Clubs at 12 locations, faith-based sites in Kansas City, and community sites in southwest and central Missouri. The curricula and their intended audiences are: Creating Lasting Connections (children 8-12 and their parents/guardians); All Stars (children aged 11-14 years); and Smart Moves (children aged 8-17 years). The curricula were provided to over 38,000 youth.

CSAP Model Programs were also implemented through the School-based Prevention and Intervention Initiative (SPIRIT) program in five schools. The programs included Peace Builders, Reconnecting Youth, Second Step, Positive Action, 2 Good For Drugs, and Towards No Drug Abuse, and Life-Skills. An estimated 5,217 students were served through the SPIRIT program.

Partners in Prevention (PIP) continued to provide on-going training opportunities through monthly meetings and a state-wide conference. A total of 833 higher education professionals, law enforcement professionals, judicial officers, and college students participated in training activities.

Mobilization

There were approximately 154 community coalitions registered with ADA. Sustainability and capacity building continued as the focus of the 11 RSCs that provided technical assistance to the coalitions. The RSC technical assistance continued to include a community assessment that addressed strategic thinking, broad diverse community membership, coalition leadership, diversified funding sources, training, and evaluation. The RSCs continued to work with local coalitions to prioritize their goals based on the outcomes of this assessment. Local teams continued to be encouraged to work with other prevention-related teams and task forces.

The statewide coalition PIP comprised of 12 Missouri universities continued to develop strategies for reducing and preventing high-risk drinking among Missouri's college students.

Alternatives

Community coalitions and community-based providers continued to offer alternative prevention activities throughout the year. Local team action plans identified alternative

activities to implement. ADA utilized the U.S. Education Office of Safe and Drug Free Schools Governor's Discretionary funds for the technical support provided by the consultant bank. The consultant bank provided training, program development, and technical assistance to teams related to specific problem areas. Over 40 consultant bank requests were approved. Approximately 400 people were served through the requests.

Alternative prevention activities were continued through PIP. The PIP statewide coalition comprised of 12 Missouri public institutions for higher education provided community service activities and youth leadership functions as alternative prevention activities.

Environmental (Social Policy)

The RSC's provided training and technical assistance to members of community coalitions on the elements of effective coalitions. New team members received education regarding alcohol and substance abuse as part of their orientation. Information on social policy issues was provided to teams via the "ACTION" newsletter of ACT Missouri. The network of community coalitions were involved at the local district levels and at the state level by testifying before legislative committees. Community team members were involved in legislation related to zero tolerance for youth alcohol use and driving, increasing excise taxes on alcoholic beverages, opposing legalization of marijuana for medical use, and reducing methamphetamine production. Community teams also acted as change agents by educating teens about alcohol use and developing strategies for changing both laws and taxation policies related to alcohol in conjunction with Missouri's Youth/Adult Alliance.

The Division of ADA continued to work with DHSS on a grant that has enabled Missouri to implement a comprehensive Fetal Alcohol Syndrome prevention effort. This project encompasses multiple risk domains and utilizes a range of preventive interventions to increase public awareness about the risks associated with any level of drinking while pregnant. These prevention efforts are expected to result in a reduction in the rate of alcohol-exposed births and will encourage proactive public policy to enhance coordination of services planned for and delivered to this population by collaborating state agencies.

Partners in Prevention (PIP) is a campus-based coalition comprised of representatives from 12 public universities. PIP's goal is to reduce binge drinking among Missouri's college students by three percentage points from FY 2000 baseline levels. An estimated 120,000 students attend PIP campuses full-time and approximately 5,600 students were served through the Missouri PIP in FY 2007. Social-norming campaigns continued to be a coordinated priority on the college campuses.

Problem Identification and Referral

The Division of ADA continued to identify and respond to substance abuse-related problems of young children of women who were receiving treatment for substance abuse in the contracted Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and their children. The focus on at-risk youth was also continued with specifically modified prevention programming provided to deaf and hearing impaired youth and adults through the operation of a “warm-line” which supports problem identification and effective referrals. In FY 2007 1,178 individuals were served through the “warm-line” service.

The Partners in Prevention campus based prevention coalition administered the Missouri College Student Health Behavior Survey which replaced the Core Alcohol and Drug Survey and was administered at the 12 publicly funded universities comprising the statewide PIP coalition. A total of 6,323 students were surveyed.

FY 2008 (Intended Use)

For FFY 2008, Missouri will continue to conduct the following activities to improve its outcome-based prevention infrastructure and service delivery, using the CSAP six strategies to report on NOMS.

* Needs assessment using federal, State and local data
* Capacity development and mobilization at the local level for block grant and other prevention providers
* Planning and collaborating across State and community stakeholders to maximize resources
* Building capacity at the State level to support communities
* Evaluating for quality assurance and needed improvement

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) will continue to implement an information dissemination strategy through multiple prevention providers. This will include utilization of three Regional Alcohol and Drug Awareness Resource (RADAR) network sites, 11 Regional Support Centers (RSC), the Statewide Resource Center, the participating members of the campus based Partners in Prevention, and the collaborative community coalition partners. Statewide information dissemination will use broadcast media to potentially reach over four million individuals aged 5 to 64 years. ADA plans to support the resource network involvement in health and prevention fairs, parades, resource fairs, and numerous other community team events to disseminate information about alcohol, tobacco, and other drug (ATOD) use and abuse to community members. Other national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3-D Month, and Alcohol Awareness Month will also continue to provide opportunities for RSCs and community coalitions to disseminate information about ATOD to their communities. The community coalitions consisting of over 2000 members will continue to be an ongoing resource to provide information at the local level throughout the state.

Merchant education materials will continue to be distributed to the RSCs for dissemination during the annual tobacco merchant education campaign. The merchant education campaign will consist of a phone call and two walk-in visits to the retailers. During the campaign, RSCs will inform retailers of the availability of technical assistance and training for their employees.

The Division of ADA's RADAR network sites located in Jefferson City, Kansas City, and St. Louis will continue to make current prevention information available to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network will provide support to local communities by providing information to community coalitions and teams about preventing teen ATOD use and providing effective intervention strategies for high risk

groups. Regional support center newsletter publications and prevention website maintenance will also continue.

The Division of ADA will continue to contract with the University of Missouri-Columbia to support the Partners in Prevention (PIP) statewide coalition comprised of 12 Missouri public institutions of higher education. The PIP, which is collaboratively funded by the Missouri Division of Highway Safety, will continue to develop strategies for reducing and preventing high-risk drinking among Missouri's college students. PIP will continue to publish a quarterly newsletter titled "Journeys", which is currently distributed to over 200 entities affiliated with at-risk youth. In collaboration with the Missouri Department of Elementary and Secondary Education, this newsletter and other informative materials for college-bound students may be electronically disseminated to every school system in Missouri. The prevention materials developed by PIP may be utilized by Missouri high-school counselors to encourage parents of college-bound students to prepare for the ATOD issues that their children will face during their college experience. These collaborative efforts will greatly increase the current distribution and dissemination of prevention materials across the state to those who may effectively utilize them with at-risk youth.

Education

The Division of ADA will continue to implement Center for Substance Abuse Prevention (CSAP) Model Programs through community-based contracts with Boys and Girls Clubs at 14 locations in Missouri. The curricula and their intended audiences are: Creating Lasting Connections, which is appropriate for children ages 8-12 and encourages parent and guardian participation; All Stars for children aged 11-14 years; and Smart Moves for children aged 8-17 years. An estimated 38,000 youth aged 8-17 will be served with these age-appropriate curricula.

Partners in Prevention (PIP) will continue to provide on-going training opportunities for higher education professionals, law enforcement professionals, judicial officers, and students on the effective prevention of alcohol and other drug abuse among Missouri college students through monthly meetings, a state-wide conference, and drive-in conferences. An estimated 1,200 will participate in training activities offered through the PIP program.

Center of Substance Abuse Prevention (CSAP) Model Programs will also be implemented through the School-based Prevention and Intervention Initiative (SPIRIT) program in five school districts. The programs provide Peace Builders, Reconnecting Youth, Second Step, Positive Action, 2 Good For Drugs, Towards No Drug Abuse, and Life-Skills. ADA anticipates serving over 5,500 youth through the SPIRIT program. High school programs will continue to be implemented.

Mobilization

Ongoing support to the approximately 154 community coalitions registered with ADA will continue for FY 2008. Sustainability and capacity building will continue to be the focus of the 11 RSCs providing technical assistance to the community coalitions. Community assessment will address strategic thinking, diversity in community membership, coalition leadership, developing diversified funding sources, training, and outcomes evaluation. The RSCs will also continue to work with local coalitions to prioritize their goals as indicated by their community assessment outcomes. Local teams will be encouraged to work with other prevention-related teams and community task forces including Caring Community partnerships and Community Betterment and Development teams. This effort will be a collaborative effort with the Missouri Department of Economic Development.

The Division of ADA will continue to contract with the University of Missouri-Columbia to support the statewide PIP coalition comprised of 12 Missouri public institutions of higher education.

Alternatives

Alternative prevention activities will continue to be supported for community coalitions and community-based providers throughout the year with support from U.S. Education Office of Safe and Drug Free Community Governor's Discretionary funds. Resources to support alternative activities for approximately 4,000 participants will be included in the local team action plans and will be made available through resources provided by ADA. Examples of anticipated alternative prevention activities include after school and weekend alcohol, tobacco, and other drug-free social and recreational activities, community betterment projects, and mentoring programs for at-risk youth.

The statewide PIP coalition comprised of 12 Missouri public institutions of higher education will continue to offer alternative activities to an anticipated 500 participants through community service activities and youth leadership functions.

Environmental (Social Policy)

The RSCs will provide training and technical assistance to members of community coalitions on the elements of effective coalitions. New team members will receive training regarding ATOD issues. Information concerning social policy issues will be provided to teams through the "ACTION" newsletter published by ACT Missouri. The network of community coalitions will continue their involvement at the local district levels and at the state level to support legislative initiatives which encourage prevention efforts that reduce youth risk. ADA anticipates the continued involvement of community team members in legislation related to zero tolerance for youth alcohol use and driving, increasing excise tax on alcoholic beverages, opposition to the legalization of marijuana for medical use, and measures to reduce methamphetamine production. ADA anticipates that the community teams will continue to act as change agents by educating teens about alcohol use and developing strategies for changing both laws and taxation policies related to alcohol.

The Division of ADA will continue to collaborate with the Department of Health and Senior Services (DHSS) to reduce the rate of alcohol-exposed births, to effect proactive changes in public policy, and to enhance service coordination and delivery to this identified high risk target population.

The Division of ADA will continue to support PIP, the coalition comprised of representatives from 12 publicly funded universities. PIP's goal is to reduce binge drinking among Missouri college students. An estimated 6,000 students will be reached through PIP in FY 2008. Social-norming campaigns will continue to be a priority for the participating college campuses.

Problem Identification and Referral

The Division of ADA will continue to identify and respond to the substance abuse related problems of young children of women who are participating in substance abuse treatment at the contracted Comprehensive Substance Treatment and Rehabilitation sites. ADA will continue to support prevention services which respond to the needs of youth and the deaf and hearing impaired populations. ADA anticipates that 1,250 individuals will be served through the "warm-line" system that provides problem identification and referral for these populations.

Partners in Prevention (PIP) will continue to administer the Missouri College Student Health Behavior Survey at the 12 publicly funded universities comprising the coalition. An estimated 6,700 college students will be surveyed across the state.

State:
Missouri

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☒ Yes ☐ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☐ Yes ☒ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT	OTHER STATE FUNDS	DRUG FREE SCHOOLS
☐ Yes	☐ Yes	☐ Yes
☒ No	☒ No	☒ No
☐ Unknown	☐ Unknown	☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☐ Yes ☒ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? ☒ Yes ☐ No ☐ Unknown

Dissemination of materials? ☒ Yes ☐ No ☐ Unknown

Media campaigns? ☒ Yes ☐ No ☐ Unknown

Product pricing strategies? ☒ Yes ☐ No ☐ Unknown

Policy to limit access? ☒ Yes ☐ No ☐ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☒ Yes ☐ No ☐ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☐ Yes ☒ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☒ Yes ☐ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	☐	☐	☒	☐
Alcohol	☐	☐	☒	☐
Marijuana	☐	☐	☒	☐

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other durg abuse prevention (HP 26-3)? 155

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

Missouri

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), has maintained the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. Missouri continues to offer CSTAR services to women and children suffering from the effects of substance abuse. CSTAR comprehensive programs allow women and their children to receive multiple levels of care depending on assessed need. CSTAR programs are available in each region of the state. ADA has maintained certification standards which require substance abuse treatment services for pregnant or postpartum women or women with custody of children be the first priority. During FY 2005, 540 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR Certification Standards and contract requirements.

Nursing services are available at the program site and a community support worker assists the consumer with necessary medical referrals and scheduling of appointments. Childcare is provided on-site or the program makes arrangements for child care at all CSTAR programs specializing in treatment of women and children.

Contract monitoring occurs annually through Safety and Basic Assurances Reviews at the program site. This site audit includes the Area Treatment Coordinator reviewing the program's practices and the Block Grant Requirement Checklist to ensure compliance with Block Grant requirements. Certification surveys occur on a three year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care and children are receiving safe and appropriate childcare. Monitoring schedules are current and programs are in compliance.

FY 2007 (Progress)

The Division of Alcohol and Drug Abuse continues to provide specialized Comprehensive Substance Treatment and Rehabilitation services for pregnant women and women with dependent children. During FY 2006, 589 pregnant women were admitted to substance abuse treatment services. This year, additional Medicaid money is available for the treatment of pregnant women. Program staff provided orientation sessions to medical facility staff about the availability and types of treatment services available to pregnant women and their children. Evidence-based treatment, including trauma-informed care and services, continues to be implemented in these programs.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse will continue to provide specialized Comprehensive Substance Treatment and Rehabilitation services for pregnant women and women with dependent children. The implementation of evidence-based practices will continue to be a priority as well as quality assurance monitoring of this treatment. The monitoring of programs will continue to be completed annually. An annual Safety and Basic Assurances Reviews that includes a review of contract, certification and block grant requirements will be completed for each agency. A certification survey of program practices and operations conducted by a team of treatment specialists will be completed every three years for each agency.

Missouri

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:
Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2005. In a narrative of up to two pages, describe these funded projects.

Attachment B (Part 1)

Treatment for women in the State of Missouri has been enhanced over the past fifteen years due in part to the Block Grant funds. The Missouri Department of Mental Health Division of Alcohol and Drug Abuse (ADA), has moved from providing treatment for women only in gender integrated programs to creating programs designed specifically for women and their children. Twelve contracts have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children and offer multiple treatment site locations across the state. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. All of the programs provide for licensed daycare services for the children accompanying their mothers to treatment. One program's on-site daycare has been accredited by the National Association for the Education of Young Children. The dependent children receive treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2005 Block Grant funds for at least a 5% set aside has been exceeded.

Urban hospitals in St. Louis and Kansas City noted the increase in drug-affected children in the late 1980's. By 1988, the number of impaired infants brought about an organized request to ADA to begin treating pregnant and postpartum women and their children. Concurrently, the CSTAR program was being developed to meet the needs of this specific group of women and their children. Women are defined as requiring treatment when their use of alcohol and other drugs has caused dysfunction in any area of their lives. By offering a continuum of care, CSTAR is suited to match the level of care to the assessed needs of the woman and her children. This continuum of care is described below.

Continuum of Care Provided

Community-based Primary Treatment:
This is the most structured and intensive treatment in the continuum of care, and is provided in a trauma sensitive environment. Services are provided five to seven days per week. Treatment is provided in a menu of services referred to as Day Treatment, which includes up to nine hours per day of group and individual counseling, group education, and structured recovery support activities. Also available at this level of care are community support, family therapy, trauma coping skills, residential support and day care for dependent children. Age appropriate assessment and co-dependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Intensive Outpatient Rehabilitation:
This treatment is designed for women who have a home environment supportive of recovery or are living in approved housing and present less severe symptoms of substance abuse. Women who have completed a more intense level of treatment are

transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive an intermediate level of support and treatment service. Treatment services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are provided each week. Treatment is provided in a trauma sensitive environment and consists of a menu of services including; group counseling and education, individual counseling, community support, family therapy, trauma coping skills and day care for dependent children. Age appropriate assessment and co-dependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Supported Recovery:
This level of care provides service on a regularly scheduled basis, usually weekly. Women who are assessed as not needing intense or structured clinical services may begin substance abuse treatment at this level on the continuum of care. Women who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities to interact within their families and community while continuing to receive regular reinforcement of treatment principles. The frequency of services will be determined by the assessed clinical needs of the woman. Treatment is provided in a trauma sensitive environment and consists of a menu of services including; group counseling and education, individual counseling, community support, family therapy, trauma coping skills and day care for dependent children. Age appropriate assessment and co-dependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Specialized Treatment

Women are offered group education on a wide array of topics such as drug education, communication skills, anger management, coping with trauma, mental health education, and relapse prevention. Group counseling is offered to allow consumers to explore emotional issues and work towards healthy self image, relationships, and lifestyles. Individual counseling allows for further exploration and working towards specified individualized treatment goals.

Child care is provided at all levels of CSTAR programming for women while they attend treatment sessions. State Certification Standards require each program to be a licensed daycare facility for children. A child therapist is required on each program staff to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs. Codependency counseling and family therapy are provided for all persons identified with a need for these services.

Women who are homeless when they enter treatment may receive housing assistance from ADA while participating actively in treatment. Community housing is time limited and intended as a bridge to other, long term housing arrangements. The stipend for community housing is a maximum of $500 and can be used to pay rent, initial deposits, utilities and local telephone service.

All women and children who enter treatment are provided health screenings to identify health deficits or needs for medical intervention. Within the CSTAR programs, registered nurses are on duty to assist mothers and their children to achieve health goals. The nurses on-site at each facility offer medical services, referral, and education for all children and families. Each child is required to have a current physical exam and current immunizations. The community support workers assist the consumers in arranging medical appointments and obtaining transportation. Close associations with local health clinics, hospitals and doctors provide prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. All CSTAR programs conduct an HIV/STD/TB risk assessment for all consumers at admission. Pre and post test counseling for HIV/AIDS, STD and TB are available on site or by referral at all CSTAR women's programs. This innovative healthcare provision was a result of the FY 1997 mandate to increase and improve services for women.

During FY 2007, a specialized communication protocol was developed to facilitate communication between primary care physicians (PCP), case managers for the Medicaid managed care plans, Women and Children CSTAR providers, and ADA's Clinical Utilization Review Unit. Pregnant women entering the Medicaid managed care system at their physician's office, screening by a CSTAR Women and Children provider or Medicaid managed care plan review will be asked to consent to sharing only clinically relevant and appropriate information to improve continuity of care. This will ensure pregnant women and their child will have access to all available treatment and support services that meet their specialized clinical needs.

Dramatic results have occurred due to the provision of treatment services specifically designed for women. In FY 2007, 6,673 women and children were treated in the CSTAR women and children programs. In FY 2007, 84 out of 89 babies born to women in CSTAR programs were born drug free. In addition, 91 children were returned to their mother's custody from the Children's Division because their mothers had regained their ability to manage healthy families and live productive lives. The emotional rewards and cost savings from these program measures alone support the cost effectiveness of continuing specific substance abuse treatment for women and children. The State is moving towards a standardized, outcome-based system of monitoring consumer improvement on numerous domains. Implementation of evidence-based practices to treat this special needs population and quality improvement are on-going goals.

Missouri

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2005 block grant and/or State funds?

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2005 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B (Part 2)

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The capacity of Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in all three levels are limited by the amount of General Revenue and Medicaid dollars available. However, the residential component at facilities is limited to 16 beds for the primary consumers and ten beds for children. Housing can be made available for families that are homeless or alienated from their families of origin. All the women's facilities have access to supportive housing money, and therefore can offer additional safe housing options.

The number of consumers served in FY2005 in all three levels of care at the women's treatment programs, by agency, was:
BASIC – 471;
Bridgeway Counseling Services, Inc. – 1180;
Family Counseling Center of Missouri, Inc. – 707;
Family Counseling Center, Inc. – 552;
Family Self-help Center – 553;
Hannibal Council on Alcohol and Drug Abuse – 485;
Alternative Opportunities – 695;
New Beginnings Alt-Care – 458;
Queen of Peace Center – 1162;
Renaissance West, Inc. – 554;
Research Mental Health Services – 897;
Research Mental Health Services Alt-Care - 458.

A list of all women and children's CSTAR programs in Missouri, including the sub-State Planning Area (SPA) and the National Federal Registry (NFR) ID, is as follows:

Black Alcohol/Drug Service Information Center (BASIC)
Locust, Suite 800
St. Louis, MO 63103
Allocated funds FY 2005 $597,995
SPA: Eastern Region
NFR ID: MO100880

Bridgeway Counseling Services
307 North Main
St. Charles, MO 63301
Allocated funds FY 2005 $948,102

SPA: Eastern Region
NFR ID: MO101136, MO101458

Family Counseling Center of Missouri, Inc.
McCambridge Center for Women
201 North Garth
Columbia, MO 65203
Allocated funds FY 2005 $810,057
SPA: Central Region
NFR ID: MO101003

Family Counseling Center, Inc.
Cape Girardeau CSTAR
20 South Sprigg, Suite #2
Cape Girardeau, MO 63701
Allocated funds FY 2005 $825,079
SPA: Southeastern Region
NFR ID: MO101123

Family Self-Help Center
Lafayette House Serenity Program
Box 1765, 1809 Connor Avenue
Joplin, MO 64802
Allocated funds FY 2005 $705,413
SPA: Southwestern Region
NFR ID: MO101029

Hannibal Council on Alcohol and Drug Abuse
146 Communications Drive
Hannibal, MO 63401
Allocated funds FY 2005 $734,090
SPA: Northern Region
NFR ID: MO101219

Alternative Opportunities
Carol Jones Recovery Center for Women
2411 West Catalpa Street
Springfield, MO 65807
Allocated funds FY 2005 $701,229
SPA: Southwestern Region
NFR ID: MO903879

New Beginnings Alt-Care
3901 N Union Blvd, Suite 101
St. Louis, MO 63115-1130
Allocated funds FY 2005 $900,658

SPA: Eastern Region
NFR ID: MO102092

Queen of Peace Center
325 North Newstead
St. Louis, MO 63108
Allocated funds FY 2005 $920,291
SPA: Eastern Region
NFR ID: MO100591

Renaissance West, Inc.
5840 Swope Parkway
Kansas City, MO 64127
Allocated funds FY 2005 $869,452
SPA: Western Region
NFR ID: MO100898

Research Mental Health Services North Star Recovery Services
(Two programs; Alt-Care women's Correctional and a Women and Children Program)
2801 Wyandotte
Kansas City, MO 64108
Allocated funds FY 2005 Women and Children $874,637
Allocated funds FY 2005 Alt-Care Women's Correctional $900,658
SPA: Western Region
NFR ID: MO101094

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY2004 Block Grant funds?

Treatment for women in the State of Missouri has continued to expand over the past fifteen years, due in part to the block grant funds. Missouri's Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women in gender integrated programs to developing programs designed specifically for women and their children. Twelve provider contracts with multiple treatment site locations have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children in Missouri. Another program has on-site daycare accredited by the National Association for the Education of Young Children. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. Dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2004 block grant funds for at least a 5% set aside has been exceeded.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The specialized programs to meet the needs of pregnant women and women with dependent children are monitored on a regular basis. All CSTAR treatment programs receive a site Certification Survey every three years from a team of treatment certification specialists. The programs are reviewed for compliance with certification standards for CSTAR programs which reflect the accepted standard of care in substance treatment. In addition, Area Treatment Coordinators perform annual Safety and Basic Assurances reviews which include a review of compliance with Block Grant requirements. The area Treatment coordinators also provide technical assistance visits when necessary. Representatives from each women and children's program meet regularly to collaborate with ADA staff on developing issues and trends.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The State uses data reported by the contract providers on a routine basis for monitoring the treatment capacity and utilization by women. The Department of Mental Health maintains a central data system that identifies, among other data, the services provided, number of consumers and demographics (including pregnancy at admission) of consumers. Requests for treatment by women have increased substantially over the past fifteen years. In 2000, a Placement of Expanded Treatment Services document was developed to assist ADA in placement of new CSTAR – Women and Children's programs as funds became available. Through these mechanisms, areas of the state that require additional treatment resources are identified and new programs are planned.

5. What did the State do with FY 2005 Block Grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Missouri has been a leader in providing quality substance abuse treatment services to women and their children. ADA has 12 contracts providing CSTAR programs specifically for women at multiple locations. There are an increasing number of women served in state funded programs. The number of women and children treated in CSTAR Programs has increased from 2,548 in FY 1995 to 6673 in FY 2005.

Missouri

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

Treatment providers were required to admit persons who abused intravenous drugs within the past thirty days or were in imminent danger of relapse. Provider contracts require these persons be admitted within 14 days of request. The CTRAC information system, designed and maintained by the Missouri Department of Mental Health, has a registration option of screening/waiting rather than admission. The Division of Alcohol and Drug Abuse (ADA) encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate intensity are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA includes block grant intravenous drug abuser treatment requirements in its awarded contracts. Compliance has been consistently monitored with the Certification Survey process and annual Safety and Basic Assurances Reviews which includes the Block Grant Requirement Checklist.

FY 2007 (Progress)

The Division of Alcohol and Drug Abuse (ADA) is engaged in the implementation of the Customer Information Management, Outcomes and Reporting (CIMOR) information system which has been phased in since October, 2006. CIMOR developed a registration option of screening/waiting pending admission that will become functional in FY 2008. This will allow ADA to continue to identify intravenous substance abusers who are waiting for treatment options. These individuals will continue to receive contact from providers and interim treatment until they can be admitted into clinically appropriate treatment. Currently, there are 2,290 identified consumers participating in contracted treatment throughout the state who classify their primary route of drug administration as intravenous.

ADA continues to utilize certification surveys and annual Safety and Basic Assurances Reviews with the Block Grant Checklist to ensure compliance. Agencies found to be out of compliance are identified and an action plan to achieve contract and standard compliance is required. Technical assistance, consultation, and focused compliance reviews are applied to those treatment agencies serving intravenous drug users to ensure consistent compliance and provision of high quality service to the high-risk intravenous drug abusing consumer.

Provider staff continue to participate in the collaborative regional cross-training exercise with the Department of Health and Senior Services (DHSS). They share information on current epidemiological health trends for TB, HIV/AIDS, STDs, hepatitis, effective risk reduction practices, and on other health needs of intravenous drug users. The screening and risk assessment training will increase provider staff utilization of effective targeted risk reduction intervention strategies to address the high-risk behaviors of intravenous drug users.

Screening tools and hepatitis curriculum were provided to all contracted treatment providers in the fall of 2006. ADA encourages these providers to utilize these materials to train staff and consumers. DHSS has also made available free Hepatitis A and B vaccines to all consumers who are receiving substance abuse treatment services. ADA encourages all providers to assist their consumers to access Hepatitis A and B vaccines at their county health departments.

FY 2008 (Intended Use)

The Customer Information Management Outcomes and Reporting (CIMOR) information system will begin to capture the consumer screening/waiting option to monitor pending admissions for treatment. Consumers will be admitted to treatment, referred to other providers for immediate treatment or receive interim services until clinically appropriate treatment is available. Treatment agencies serving intravenous substance abusers will continue to receive consultation and technical assistance concerning the application of effective screening and intervention techniques to reduce the risk of infectious and blood borne communicable diseases which include TB, HIV/AIDS, STDs and Hepatitis. Annual Safety and Basic Assurances Reviews with the Block Grant Compliance Checklist will continue to be conducted by regional staff. This will ensure compliance with Block Grant requirements and quality of services provided.

The Division of Alcohol and Drug Abuse (ADA) contracted providers will be encouraged to continue their active participation in regional cross-trainings with the Department of Health and Senior Services prevention and care providers. This training will enhance their knowledge of effective screening and referral processes for health services and effective utilization of science-based successful prevention and intervention strategies for TB, HIV/AIDS, STDs, and hepatitis in order to reduce the frequency of high risk behaviors.

Missouri

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2005 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C

1. Intravenous drug abusers include all substance abusing persons whose primary, secondary or tertiary route of administration is by needle, whether intravenously or intramuscularly.

2. Throughout FY 2005, all providers operated at or near capacity. Agencies not at capacity were quickly filled with referrals from waiting lists from other treatment programs. Providers are contractually mandated to adhere to Block Grant requirements. No official notification of reaching 90% capacity is formally sent to ADA however when applicable, programs communicate with staff at the district offices regarding their capacity. If at capacity, programs make referrals to other resources in the community; for example, private pay opioid or detoxification programs. The new CIMOR information technology system for DMH has a registration option of screening/waiting rather than admission. ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. This has proven to be an effective process. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during Certification Surveys and Safety and Basic Assurance Reviews. Agency admissions of priority populations, to include intravenous drug users, and management of waiting lists is discussed and monitored during certification and Safety and Basic Assurance Review (SBAR) visits, as well as, during technical assistance visits that might be conducted throughout the year. Regional staff conducting these reviews are trained to understand contract requirements and to apply them to substance abuse treatment programs. Programs demonstrate compliance with capacity requirements by conducting a brief telephone screening and scheduling an assessment/admission date for individuals requesting service. Programs also demonstrate compliance by referring clients to other providers when unable to admit in a timely manner due to being at capacity. As part of the ATR grant, PR+ programs are required to offer several treatment options as part of the voucher system, and thus demonstrating that consumers have choices within our treatment system.

3. Treatment providers were required to admit persons who were intravenous drug users within the past thirty days or who were in imminent danger of relapse. Provider contracts require these persons be admitted within 14 days of request. If at capacity, programs will make referrals to other resources in the community; for example, private pay opioid programs or detoxification programs. The information system designed and maintained by the Missouri Department of Mental Health has a registration option of screening/waiting rather than admission. ADA encourages each provider to maintain contact

with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. This has proven to be an effective process. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during Certification Surveys and Safety and Basic Assurances Reviews.

4. The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA), encourages certified substance abuse treatment providers to conduct outreach services to consumers needing treatment to address intravenous drug use. Providers are encouraged during certification surveys to engage consumer's families in treatment and to address family intravenous drug use. During the 2007 Spring Training Institute, eight training sessions provided information relevant to IV drug use treatment protocols. ADA is collaborating with treatment providers and the Missouri Department of Health and Senior Services (DHSS) to present blood borne disease prevention information to consumers and to utilize appropriate HIV and Hepatitis screening tools during consumer admission to treatment. Additionally, ADA is collaborating with treatment providers, DHSS and the Missouri Department of Corrections to educate consumers about treatment options for intravenous drug abuse.

Missouri

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a)
   (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

2. Tuberculosis Services 42 U.S.C. 300x-24(a)
   (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b)
   (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Attachment D

1. Notification of Reaching Capacity

All contracted substance abuse treatment agencies in Missouri's publicly funded system of care continue to remain at or near capacity. Monitoring procedures are in place to assist consumers in accessing treatment as quickly as possible. Agency activity levels are monitored at the regional level through the Regional Administrators and Area Treatment Coordinators. During the first quarter of FY 2007, the CTRAC information system designed and maintained by the Missouri Department of Mental Health (DMH) had a registration option of "screening/waiting" rather than admission. The DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR) in October, 2006, which offers all organizations the option of using a tool in this system to manage waiting lists for primary treatment with residential support. This is available for access to all the organizations that have contracts with the Division of Alcohol and Drug Abuse (ADA). ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have also developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating treatment services throughout the state. ADA has a toll-free number advertised for consumers to call for referrals. Regional staff receive the calls and make referrals to treatment programs in the consumer's area.

No problems were identified and thus, no corrective action was taken.

2. Tuberculosis Services

ADA collaborated with the Missouri Department of Health and Senior Services (DHSS) to access current information and training information related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain referral relationships with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. The services provided included educational information about tuberculosis, related health risks and risks of transmission. Also, tuberculosis testing services were provided to determine whether the individual has been infected with mycobacterial tuberculosis, and for those testing positive, referral for appropriate medical evaluation and treatment.

All contacted substance abuse treatment facilities are required by contract to provide access for tuberculosis testing. Some facilities provide testing on site while others refer consumers to the county health department. The treatment facilities are required to maintain collaborative relationships with their county health departments. Consumers may have access to testing and health care services at any time during their treatment.

Agencies may not deny access to treatment based on a positive tuberculosis test result providing the individual does not have active disease. Treatment providers are required by contract to make appropriate referrals for persons seeking services who are not admitted to their program. Treatment providers may request assistance from county health department staff to observe their consumers taking preventive medicine when a positive tuberculosis skin test is identified.

The Area Treatment Coordinator or a treatment specialist from ADA is available to assist if an agency has difficulty finding services or has concerns about referring someone with positive tuberculosis test results. ADA staff may assess the needs of the consumer, advise agency staff of procedures and protocols or, if necessary, seek assistance from the DHSS, Bureau of Tuberculosis Control, in determining appropriate services and available medical resources.

Training and education opportunities are available to provider staff through DMH and DHSS. The Division's treatment specialists, District Administrators, and Area Treatment Coordinators will continue to work with treatment providers and county health departments to maintain and improve tuberculosis services. Through site Certification Surveys, Safety and Basic Assurances Reviews, and technical assistance visits, ADA will monitor tuberculosis services including; screening, referral, testing procedure, counseling, and confidentiality. Certification surveys are conducted every three years, Safety and Basic Assurance Reviews are conducted during the years that the certification is not performed, and technical assistance visits are provided as needed.

The infection control recommendations and protocols for substance abuse treatment providers include, but are not limited to the following procedures: screening of patients; identification of those individuals who are at high risk of becoming infected; and meeting all state reporting requirements while adhering to federal and state confidentiality requirements.

No problems were identified and thus, no corrective action was taken.

3. Treatment Services for Pregnant Women

Contracts require that all service providers specializing in women's treatment must give priority to pregnant women seeking admission to treatment. The Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) has maintained the delivery of specialized CSTAR services to pregnant women and mothers with dependent children. Missouri continues to offer Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs services to women and children suffering from the effects of substance abuse. CSTAR programs allow women and their children to receive multiple levels of care depending on assessed need. CSTAR programs are available in each region of the state. ADA has maintained certification standards which require substance abuse treatment services for pregnant or postpartum women or women with custody of children are the first priority. CSTAR certification standards (9 CSR 30-3.190

Specialized Program for Women and Children) state that “Priority shall be given to women who are pregnant or postpartum” and, “The program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria.” During FY 2005, 540 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR Certification Standards and contract requirements. During FY 2006, 589 pregnant women were admitted to substance abuse treatment services.

Nursing services are available at the program site and a community support worker assists the consumer with necessary medical referrals and scheduling of appointments. At all CSTAR programs specializing in treatment of women and children childcare is provided on-site or the program makes arrangements for childcare.

Contract monitoring occurs annually through Safety and Basic Assurances Reviews at the program site. This review includes the Area Treatment Coordinator reviewing the program’s practices and Block Grant Requirement Checklist to ensure compliance. Certification surveys occur on a three year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare. Monitoring schedules are current, and programs are in compliance. As no problems were noted, no corrective actions were taken.

Missouri

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Missouri Department of Health and Senior Services to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs.

FY 2007 (Progress)

Contracted treatment providers are required to make tuberculosis skin testing available to all consumers in their programs. Contracted treatment providers are required to maintain effective linkages with local health departments to assist treatment program staff with consumer testing and monitoring efforts. Providers are monitored annually for compliance by the Safety and Basic Assurances Reviews process to ensure that TB-positive consumers are identified and receive treatment services and to ensure that effective referrals are made for health services in collaboration with local health departments. The Missouri Department of Health and Senior Services (DHSS) offers assistance to contracted providers to procure TB testing supplies and they continue to provide follow-up diagnostic services for consumers who do not have health care resources. The DHSS has demonstrated their commitment to the provision of consistent TB services at the community level. Residential and opioid treatment programs are required to monitor consumer compliance with medications to encourage therapeutic response. The provider certification process assures that consumer medication compliance is addressed during the course of treatment.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to make tuberculosis risk assessment, testing, and risk reduction education available to all treatment consumers. The provision of tuberculosis specific services will continue to be monitored with annual Safety and Basic Assurances Reviews. ADA will continue to require contracted treatment providers to maintain effective linkages with their community health departments to ensure that consumers access and participate in tuberculosis services. Contracted providers will continue to receive ADA support, technical assistance, and direct intervention at the community level to access TB services. ADA will continue to offer technical assistance to encourage a successful partnership between ADA contracted providers and Department of Health and Senior Services community health departments.

Missouri

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2007 (Complinace)

Missouri is not a designated state.

FY 2007 (Progress)

Missouri is not a designated state.

FY 2008 (Intended Use)

Continued efforts will be made to decrease perinatal HIV transmission. The Division of Alcohol and Drug Abuse (ADA) will continue to require all Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children to coordinate the prenatal care of all pregnant consumers. This practice will ensure that female consumers have access to prenatal care to encourage the consumer to address the issue of HIV testing with their physician and the treating medical facility.

ADA and the Department of Health and Senior Services (DHSS) will continue to collaborate in strengthening regional provider service networks to promote knowledge exchange between ADA and the DHSS providers. Regional cross-training will be provided to update prevention and substance abuse providers with current health epidemiological trends to encourage effective HIV/TB/STD and hepatitis risk reduction strategies. ADA contracted substance abuse treatment and prevention providers will be encouraged to maintain effective working partnerships with community health and community prevention service providers to meet the needs of their at-risk consumers.

The DHSS provides HIV pre-and-post test counseling training at no cost to all Missouri substance abuse treatment providers. DHSS also provides free training to all contracted substance abuse treatment provider who wish to perform on-site HIV testing. ADA provides technical assistance to all contracted providers who wish to provide on-site HIV testing services. ADA staff members facilitate provider access to DHSS training and technical assistance.

The DHSS has encouraged ADA to address the co-infection rate of HIV and Hepatitis C among the IV drug use population. ADA will continue to require assessment for hepatitis risk with the initial assessment process. ADA contracted providers will continue to be encouraged to include hepatitis educational curriculum with their HIV consumer education as a risk reduction strategy.

The DHSS has continued to sponsor a statewide Hepatitis Plan of Action to address prevention and care of hepatitis. A designated ADA staff member is an active participant of this work group. Hepatitis prevention training and related hepatitis training curricula has been offered to all contracted ADA providers. Continued regional training efforts will encourage effective prevention of hepatitis to meet the needs of the substance abuse population. Hepatitis A and B vaccines are made available at no cost to any consumer of a substance abuse treatment program. ADA staff members assist with access to this service.

ADA will continue to encourage the Partners-in-Prevention (PIP), a university and college campus-based prevention program, to maintain regional collaborative partnerships with the Statewide Community Planning HIV Prevention Group to encourage their utilization of effective HIV risk reduction strategies with their college population. Members from the Community Planning Group will provide HIV intervention technical assistance and training to member campuses to encourage the provision of

effective HIV intervention. The PIP annual Meeting of the Minds Conference will include effective HIV intervention training.

ADA will collaborate with DHSS to provide technical assistance to contracted substance abuse providers who would like to provide rapid HIV testing. Currently, there are no contracted substance abuse providers performing on-site Rapid HIV testing.

Missouri

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))
For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:
Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);

- the role of the single State authority (SSA) for substance abuse prevention and treatment; and

- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;

- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;

- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and

- technical assistance.

Attachment E

The Division of Alcohol and Drug Abuse (ADA) has provided TB and HIV services in the four publicly-funded methadone programs, and other selected treatment programs since 1989. Linkages between early intervention services for HIV and the IVDU Outreach Programs included methadone service providers as well as other identified efforts, particularly in St. Louis and Kansas City.

Since July 1, 1993, all substance abuse treatment programs have provided TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. During FY 2007 $463 was spent on TB tests by Department of Health and Senior Services (DHSS). All consumers, whether admitted or not, are offered the service. Follow-up counseling and ongoing services are then provided collaboratively between the substance abuse provider and the health clinic. An ADA Treatment Specialist coordinates the HIV and TB services with the DHSS, local county health departments, and substance abuse programs to ensure services are available to all consumers.

In FY 2007 these services and local linkages between substance abuse programs and local clinics were evenly distributed statewide and involved all contracted program sites. In FY 2007 $51,689 was spent on TB services for clients who were in substance abuse treatment. All consumers received a HIV/STD/TB/Hepatitis Risk Assessment at admission to treatment and appropriate referrals were made. Pre-and post-test counseling, testing, and HIV education was available to consumers in substance abuse treatment. A total of $41,537 was spent on TB pre-and post-test counseling.

A Treatment Specialist from ADA maintained continued contact with contracted agencies and coordinated technical assistance education. A qualified contracted provider conducted regional trainings for treatment providers regarding HIV Prevention and Pre/Post Test Counseling. Additional services were provided by the Department of Mental Health, in the form of technical assistance and consultation. ADA adhered to the protocols established by the U. S. Centers for Disease Control and Prevention and DHSS.

All offenders receiving substance abuse treatment within the Missouri Department of Corrections are tested with a 2 step test at intake. This is performed and read by licensed nurses. Patient education is also provided. Testing is performed annually in the birth month or if symptomatic or exposed to an active case. Those who are symptomatic or have positive tests/x-rays/sputum are isolated in respiratory isolation. They remain there until TB is ruled out or until treatment is proven successful by negative sputum tests. Those with a positive test, indicating exposure, but without active disease are given prophylactic treatment directly observed by nursing staff. Those with active disease are given medication and housed in respiratory isolation until no longer contagious. Those exposed to active cases are tested. All positive tests are reported to the Department of Health. If an active case is identified we work with the Dept. of Health to develop an action plan. A total of $9,690 was spent by the Missouri Department of Corrections on the above TB services.

The responsibility for public health and communicable diseases is a secondary role, requiring close coordination of policy and program priorities between the DHSS and ADA. ADA has a current Memorandum of Understanding (MOU) with DHSS which identifies the on going partnership related to prevention of communicable disease. This MOU identifies that ADA will continue to collaborate with DHSS to strengthen community access to and utilization of HIV prevention and care services, STD, Hepatitis, and TB educational, screening, and treatment services. Continued technical assistance and regional cross-training are planned for delivery to all regions in the state as identified in the current MOU between DHSS and ADA.

Missouri

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2005 (Compliance): (participation OPTIONAL)

FY 2007 (Progress): (participation OPTIONAL)

FY 2008 (Intended Use): (participation OPTIONAL)

FY 2005 (Compliance)

In FY 2005, the Department of Mental Health, Division of Alcohol and Drug Abuse, opened one (1) house for women and (5) men's Oxford Houses. A continued need for safe and affordable housing exists in Missouri and indications are this will be the case for many years to come. Housing specialists employed by the state continue to monitor and provide technical assistance to 43 houses for men and 11 houses for women.

FY 2007 (Progress)

The Department of Mental Health, Division of Alcohol and Drug Abuse, continues to support the Oxford House program within the State of Missouri. Through careful selection of prospective house locations, the stabilization of the Oxford House program has been maintained.

FY 2008 (Intended Use)

The housing needs of individuals in recovery will continue to be a high priority in the future. The State of Missouri will continue to support the group home program to assure adequate housing for individuals completing treatment and seeking safe and affordable housing. The Department of Mental Health, Division of Alcohol and Drug Abuse, will continue to assist in opening new housing and providing technical assistance to the Oxford House program.

Missouri

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in Fiscal Year 2005 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2005 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

Attachment F

The Anti-Drug Abuse Act of 1988 (Pub. I. 100-690, approved November 18, 1988) amended Subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x) by adding a new section 1916A establishing a program entitled Group Homes for Recovering Substance Abusers.

Under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Missouri Department of Mental Health (DMH) established the Group Home Revolving Loan fund by contract with the Missouri Housing Development Commission (MHDC) effective August 11, 1989. In 2002, the DMH contracted with Oxford House, Inc. to manage the Revolving Loan Fund. States were required to establish the revolving fund in the amount of $100,000. States must establish, directly or through the provision of a grant or contract to a non-profit entity, a revolving loan fund.

By law, individual loans for the establishment of programs to provide housing may not exceed $4,000 each. The loans are to be repaid within a 2 year period. These funds are to be used to provide start-up loans to groups of recovering individuals.

As stipulated in accordance with the specifications in the Block Grant legislation, the loans have specific requirements. An application must be submitted to the DMH and signed by at least six recovering individuals who have completed alcohol and/or drug treatment. They must want to start a self-run, self-supported alcohol and drug free house. After reviewing the application, the DMH forwards the application to Oxford House World Services where a review is completed; a check is then forwarded to the applicant (borrower). Loan checks are not made payable to individuals but in the name of the house which is designated by the name of the street or town where it is located. Loan repayment schedules are in 12, 18, or 24 month installments. No loan payments are due for the first 30 days after the original loan is issued. No interest is charged to the borrower on the principal on the loan. Repayments are made to Oxford House World Services where they are deposited into the revolving loan fund. Late payments from the borrower are assessed a 20% or $25 penalty if not received as scheduled.

There were six (6) loans issued in 2005 totaling $19,700. The amount of funds available at the time of these loans was between $13,513 and $20,000. Other existing loans were being repaid while new loans were approved to open the new houses. A monthly report is forwarded by Oxford House World Services giving details for each loan and payment schedule. Every house that has a loan receives a payment book and is contacted if scheduled payments are late or have not been received. There have been instances of late payments or loan defaults during the past year due to vacancies, unexpected increases in utility bills, house closings, or changes in the house such as switching form a men to women's house. However in FY 2005 there were no loan defaults. When payment issues arise, a letter is sent to the house reminding them of their payment obligations. In cases where a house closes, the loan is reassigned to the Oxford House Chapter or another house until the loan is repaid.

On a monthly basis, the Oxford House Drug Free Group Home Specialist receives the loan report from Oxford House World Services detailing the activity of every house. Any house experiencing financial difficulty is contacted and counseled by the Drug Free Group Home Specialist who is employed by the Department of Mental Health, Division of Alcohol and Drug Abuse. Technical assistance is provided by the Drug Free Group Home Specialist and can be obtained through an 800 telephone number. Through publications, meetings, and workshops, the Division of Alcohol and Drug Abuse has made education of the Oxford House concept a priority for legislators, communities, and local government agencies throughout Missouri.

As of June 30, 2004, 106 loans have been committed in Missouri for drug-free group homes. These homes are located in 15 Missouri cities. More than $329,000 has been loaned to open Oxford Houses in Missouri since 1989. There are 54 houses in the state where 358 men and 90 women make their home.

Missouri was one of a few states that initially welcomed the Oxford House program when it was first offered. Since that time, Missouri has seen its share of successes and failures. Because it has been through the good and tough times, Missouri recognizes the value of continuing to provide safe and affordable housing programs for individuals after their completion of substance abuse treatment.

CENTRAL REGION

Alhambra
107 E. Alhambra
Columbia, MO 65203
M 573-443-2640

Bicknell
104 Bicknell
Columbia, MO 65203
M 573-442-7084

Calico
2504 Calico St.
Columbia, MO 65202
M 573-474-0035

Cougar
600 Rogers St.
Columbia, MO 65203
M 573-442-2330

Elliott
220 Elliott Ave.
Columbia, MO 65201
W 573-256-8501

Hubble
105 Hubble St.
Columbia, MO 65201
W 573-499-0202

Leslie
19 E. Leslie
Columbia, MO 65203
M 573-256-5221

Nelwood
2501 Nelwood Dr.
Columbia, MO 65202
M 573-814-0888

Pinewood
115 Pinewood Ave.
Columbia, MO 65203
W 573-234-7449

Pioneer
1213 Pioneer St.
Columbia, MO 65202
M 573-886-9550

Proctor
314 Proctor Dr.
Columbia, MO 65202
M 573-874-9610

Quail
2614 Quail St.
Columbia, MO 65202
M 573-3900

Sondra
921 Sondra
Columbia, MO 65203
M 573-875-5721

Willowbrook
2501 Willowbrook Ct.
Columbia, MO 65203
M 573-474-0741

West Broadway
2402 W. Broadway
Columbia, MO 65203
W 573-445-3699

EASTERN REGION

Allendale
3127 Meramec St.
St. Louis, MO 63118
M 314-353-5823

Chippewa
6408 Chippewa
St, Louis, MO 63109
V 314-353-2771

Clayton
6957 Clayton Rd.
St. Louis, MO 63110
M 314-863-7669

Fairview
2171 Hwy. 61
Festus, MO 63028
M 636-937-2514

Gravois
3943 Gravois
St. Louis, MO 63116
M 314-772-1303

Humphrey
3542 Humphrey
St. Louis, MO 63118
M 314-865-2928

Jarman
4506 S. Grand
St. Louis, MO 63118
W 314-351-1567

Kensington
5058 Kensington
St. Louis, MO 63108
M 314-367-7962

Lusher
11876 Lusher Rd.
St. Louis, MO 63138
M 314-741-7536

McCausland
2017 McCausland
St. Louis, MO 63143
M 314-644-0971

McDonough
527 McDonough
St. Charles, MO 63303
M 636-947-6730

Michigan
7127 Michigan Ave.
St. Louis, MO 63111
M 314-351-2712

Monitor
3633 Meramec
St. Louis, MO 63116
M 314-752-1213

Montana
3655 Montana Ave.
St. Louis, MO 63116
M 314-351-2064

Oak Lake
11100 Oak Lake
Creve Couer, MO 63146
W 314-432-1544

Osage
2715 Osage
St. Louis, MO 63118
W 314-772-6771

Portis
4430 Arsenal St.
St. Louis, MO 63118
M 314-776-5825

Shenandoah
720 Shenandoah
St. Louis, MO 63104
M 314-446-4883

St. Charles
225 N. 5th Street
St. Charles, MO 63301
M 636-940-0741

Winfield
60 Franke
Winfield, MO 63389
M 636-566-6258

WESTERN REGION

Blue Hills
1832 E. 49th St.

Kansas City, MO 64130
M 816-923-7696

Felix
1419 Felix

St. Joseph, MO 64501
W 816-232-4773

Harrison
26 E Concord

Kansas City MO 64112
M 816-237-1925

Hillcrest
9615 Freemont
Kansas City, MO 64134
M 816-761-3948

Holmes
2741 Holmes
Kansas City, MO 64108
M 816-842-1634

Karnes
3734 Walnut Ave.
Kansas City, MO 64109
W 816-931-6731

Marlboro
1410 E. 77th Terrace
Kansas City, MO 64131
M 816-333-2267

Museum Hill
1210 Felix
St. Joseph, MO 64501
M 816-676-2323

Rockhill
5632 Charlotte
Kansas City, MO 64111
W 816-361-5670

St. Joseph
507 S. 10th Street
St. Joseph, MO 65401
M 816-232-8988

Truman
400 S. Hocker
Indepence, MO 64050
M 816-833-0222

SOUTHWESTERN REGION

Catalina
1674 S. Catalina
Springfield, MO 65807
M 417-887-7783

Grant Street
2555 N. Grant St.
Springfield, MO 65803
M 417-863-0244

Hynes
307 Hynes St.
West Plains, MO 65775
M 417-257-0383

Kerr
953 W. Kerr
Springfield, MO 65803
M 417-877-7783

Moffet
529Moffet St.
Joplin, MO 65804
M 417-623-4347

Mount Branson
1154 East Hwy. 76
Branson, MO 65613
M 47334-4696

United
1558 Cherokee
Springfield, MO 65807
M 417-866-1183

Wall
1422 S. Wall Ave.
Joplin, MO 65616
W 417-623-8981

TECHNICAL ASSISTANCE STAFF

1/800-575-7480 ADA Toll Free Number

Jacquie Lockett

314 877-0386

M=Men
W=Women
W /C=Women & Children
V=Veteran

Missouri

Goal #8: Tobacco Products

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 45 C.F.R. 96.130 and 45 C.F.R.96.122(d)).

- Is the State's FY 2008 Annual Synar Report included with the FY 2008 uniform application?
  Yes No
- If No, please indicate when the State plans to submit the report:
  mm/dd/2007

Note: The statutory due date is December 31, 2007.

Missouri plans to submit the FFY 2008 Annual Synar Report immediately upon notification of the ASR approval from the Office of Management and Budget.

Missouri

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) has developed specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children. ADA certification standards and provider contracts require that pregnant and postpartum women be given admission priority. Monitoring procedures are in place to assist pregnant women in accessing treatment as quickly as possible. Agency activity levels are monitored at the regional level through the District Administrators and Area Treatment Coordinators. The information system designed and maintained by the DMH has a registration option of screening/waiting rather than admission. ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating treatment services throughout the state. ADA has a toll-free number advertised for consumers to call for referrals. Central office or regional staff receive the calls and make referrals to treatment programs in the consumer's area. Compliance was monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

FY 2007 (Progress)

Pregnant women continue to receive admission priority as required by provider contacts and certification standards. Compliance continues to be monitored by Certification Surveys and annual Safety and Basic Assurances Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district office staff. The results of this monitoring activity demonstrate that pregnant women are being admitted to treatment and receiving services as required.

FY 2008 (Intended Use)

Pregnant women will continue to receive admission priority as required by provider contract and certification standards. Missouri will expand its Access to Recovery Grant program to the women and children's CSTAR by making recovery support services available to this population. Compliance will continue to be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

Missouri

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment G

The Single State Agency for the State of Missouri addresses the requirements for developing capacity management and waiting list systems for intravenous drug users and pregnant women through several methods:

1. Certification Standards for Alcohol and Drug Abuse Programs

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in standards which guide providers of treatment services through the Certification Standards for ADA programs. These Certification Standards are codified as state regulations in the Code of State Regulations (CSR) and filed with the Missouri Secretary of State. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.
2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.
3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;
2. Shall be responsive to the individual's request and needs; and
3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

9 CSR 30-3.190 (1) (Specialized Program for Women and Children) requires that in programs that provide treatment solely to women and children, priority is given to women who are pregnant or postpartum.

9 CSR 10-7.010 (6) (Treatment Principles and Outcomes) requires (A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria and (7) Essential Treatment Principle—Array of Services.

(A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.
2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.
3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.
4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.
5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

9 CSR 30-3.100 (14) (Services Delivery Process and Documentation) requires that the ADA conduct clinical review to "promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definition."

9 CSR 30-3.132 (5) (Opioid Treatment Program) requires "the program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive."

Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating referral resources throughout the state.

Funds Expended or Obligated for the Federal Fiscal Year two years prior to the year for which the State is applying for funds:

These certification standards are part of the ongoing operations of ADA. In addition, the statewide network of treatment providers offer an easy vehicle for communication across provider agencies on topics related to treatment capacity. No direct costs can be attributed to complying with the capacity management and waiting list requirements of the block grant.

2. Information systems:
The Client Tracking, Registration, Admission and Commitment (CTRAC) information system designed and maintained by the Missouri Department of Mental Health (DMH) had a registration option of screening/waiting rather than admission. This system was abandon at the end of September 2006.

DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR) at the beginning of October 2006, which offers all organizations the option of using a tool in this system to manage waiting lists for primary treatment with residential support. This is available for access to all the organizations that have contracts with ADA. ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available.

Funds Expended or Obligated for the Federal Fiscal Year two years prior to the year for which the State is applying for funds:

CTRAC and CIMOR are a component of the DMH's consumer information infrastructure. Costs for complying with block grant capacity management and waiting list requirements are part of the ongoing costs of this infrastructure and cannot be estimated.

3. Toll-free Telephone Number

ADA has a toll-free number advertised for consumers to call in for referrals. Either central office or regional staff receive the calls and make referrals to treatment programs in the consumer's area.

A long standing policy of ADA has been to prioritize the admission and treatment of pregnant women and intravenous drug users. These consumers are not placed on a waiting list for treatment. When members of these priority populations present for service they are promptly screened, assessed, and engaged in the level and intensity of care that is commensurate with their clinical needs. While treatment services at any level and intensity can be immediately available to members of these populations, agencies offering the residential component do not always have beds available. In such situations the ADA policy has required the agency to transition a clinically stable consumer who is not a member of a priority population from residential support to transitional or supportive housing or other appropriate housing plan, thereby ensuring room in the residence for the priority population consumer.

The above procedure has worked reasonably well in light of limited resources. Compliance with this procedure will be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

ADA does not identify costs separately for capacity management and waiting list systems; these costs are included in our administrative costs.

Missouri

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

Data from the St. Louis Targeted Cities program provide the Missouri's Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA), with a unique opportunity to evaluate the quality of consumer agency matching, consumer progress in treatment, and treatment outcomes. The standard computerized consumer assessment tool developed during this grant, Initial Standardized Assessment Protocol (ISAP), enhanced the ability of providers and ADA to perform three important functions. The ability to identify the most appropriate intensity of care for each consumer is enhanced. Data collection enabling utilization review and outcome measures was possible. Comprehensive identification of problem areas for treatment planning was also enhanced. The internet Web-based version of the Initial Standardized Assessment Protocol (ISAP) with data transported over a Virtual Private Network for confidentiality was the only Department of Mental Health (DMH) supported version of the assessment. Contracted agencies used the Internet version of the ISAP called the "Outcomes Web".

The Addiction Severity Index (ASI) was the primary assessment tool used to determine level of care for consumers age eighteen years and older. The ASI is a structured clinical interview which is typically conducted in less than fifty minutes at the time of the consumer's admission. This assessment tool encompasses seven areas of life function: medical status; employment status; drug and alcohol use; family history; family and social relationships; legal status; and psychiatric status.

The Missouri Adolescent Comprehensive Substance Assessment (MACSA) was designed by a workgroup of Missouri adolescent treatment providers. The MACSA is a structured clinical interview which is typically conducted at the time of the adolescent's admission to treatment. This assessment tool encompasses seven areas of life function: legal; school and work; behavior and emotions; friends; family; recovery environment; and placement.

All providers were using the ISAP and either batching information or using the internet virtual private network to input the data directly to a data warehouse for information retrieval by ADA. ADA staff reviewed utilization data on an agency-by-agency basis to identify major trends, problem areas, and successful outcomes. Providers utilized the computerized ISAP to assure consumers were provided the most appropriate level of care. The tool permitted greater ability to perform utilization review and outcome measurement.

Certification standards require individuals to meet eligibility criteria for admission into each level of the continuum of care.

9 CSR 30-3.120 Detoxification
(3) Eligibility Criteria: In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A

person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:

(A) Demonstrates a current inability to minimally care for one self;

(B) Lacks a supportive, safe place to reside and demonstrates a likelihood of continued use of alcohol or other drugs;

(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or

(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

9 CSR 30-3.140 Residential Treatment

(2) Eligibility Criteria: In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:

(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;

(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;

(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following:

1. Recent patterns of extensive or severe substance abuse;

2. Inability to establish a period of sobriety without continuous supervision and structure;

3. Presence of significant resistance or denial of an identified substance abuse problem; or

4. Limited recovery skills and/or support system; and

(D) A client may qualify for transfer from outpatient to residential treatment if the person:

1. Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or

2. Presents imminent risk of serious consequences associated with substance abuse.

9 CSR 30-3.130 Outpatient Treatment

(4) Community-Based Primary Treatment: This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.

(A) Eligibility for primary treatment shall be based on:

1. Evidence that the person cannot achieve abstinence without close monitoring and structured support; and

2. Need for frequent, almost daily services and supervision.

(5) Intensive Outpatient Rehabilitation: This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on:

1. Ability to limit substance use and remain abstinent without close monitoring and structured support;
2. Absence of crisis that cannot be resolved by community support services;
3. Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and
4. Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(6) Supported Recovery: This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on:

1. Lack of need for structured or intensive treatment;
2. Presence of adequate resources to support oneself in the community;
3. Absence of crisis that cannot be resolved by community support services;
4. Willingness to participate in the program, keep appointments, participate in self-help, etc.
5. Evidence of a desire to maintain a drug-free lifestyle;
6. Involvement in the community, such as family, church, employer, etc.; and
7. Presence of recovery supports in the family and/or community.

9 CSR 30-3.132 Opioid Treatment Program

(5) Admission Criteria: The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1. The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The

applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2. For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of the Division of Alcohol and Drug Abuse; and

3. An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1. The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2. At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D) The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

ADA's Clinical Utilization Review Unit makes determinations regarding the appropriate level of care for consumers according to certification standards.

(14) Clinical Utilization Review: Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B) Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C) Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1. Length of stay beyond any specified maximum time period;
2. Service authorization beyond any specified maximum amount or cost;
3. Admission of adolescents into adult programs; and
4. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA.

(D) Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.
(E) The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.
(F) Clinical utilization review may include, but is not limited to, the following situations regarding a program:
1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA regarding the utilization of particular services and total service costs; and
2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.
(15) Credentialed Staff: Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

The Division of ADA maintained contracts with Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state to provide specialized services to populations including women and children and adolescents. The CSTAR specialized programs for women and children provide treatment, rehabilitation, and other supports solely to women and their children. These programs focus on therapeutic issues relevant to women including parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. The women's CSTAR programs also provide or arrange daycare and therapeutic services for children who accompany their mother in treatment. The CSTAR specialized programs for adolescents provide treatment, rehabilitation, and other services solely to consumers between the ages of twelve and seventeen inclusive, and their families. These programs focus on therapeutic issues relevant to adolescents including recovery issues such as peer relationships, use of leisure time, and abuse and neglect; skill development such as decision-making and study skills; and information and education regarding adolescent developmental issues and sexuality. The adolescent CSTAR programs also have an emphasis on family support and involvement, as appropriate.

FY 2007 (Progress)

Eligibility criteria contained within certification standards continues to be maintained. The Clinical Utilization Review unit continues to review service plans for compliance with certification standards and appropriateness of placements in the continuum of care consistent with consumer assessment and acceptable standards of care.

The Division of Alcohol and Drug Abuse (ADA) maintains contracts with Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state to provide specialized services to populations including women and children and adolescents. During FY 2007, there were eleven women and children's CSTAR agencies and eight adolescent CSTAR agencies providing these specialized services in Missouri.

During FY 2007, CSTAR adolescent providers began using the Global Assessment of Individual Needs (GAIN) assessment instrument at admission. This is a research-based full bio-psycho-social assessment that integrates research and clinical assessment to complete diagnosis, placement, individualized treatment planning, program evaluation, and reporting requirements. The GAIN will provide a comprehensive, standardized tool with which to ensure appropriate consumer placement and service referrals.

The community based Primary Recovery Plus (PR+) programs continue to offer an array of community-based clinical substance abuse treatment services within multiple levels of care, based on the consumer's assessed needs. These services are delivered according to the genuine, free, and independent choice of provider, appropriate for the consumer's assessed needs.

The ATR funds allowed the enhancement of all existing primary recovery programs to provide the full array of services including relapse prevention and trauma services. In some cases, services were expanded into areas that are underserved. In other areas, nontraditional and faith-based organizations have been credentialed to provide recovery support services in their communities. Specific recovery support services available from credentialed nontraditional and faith-based organizations through the ATR grant include: care coordination, childcare, drop-in center, emergency/temporary housing, family engagement, pastoral counseling, individual and group recovery support, spiritual life skills, and transportation. Since the start of the ATR grant, on April 1, 2005, a total of 120 recovery support providers have been credentialed.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to review utilization data to identify patterns of success by provider agency. ADA is working on fine-tuning the ability to retrieve data in a meaningful fashion. ADA will continue to implement the outcomes measurement plan and assure reliable outcomes data is being collected to meet the federal requirements.

The clinical utilization review unit will continue to review service plans for compliance with certification standards, appropriateness of placements in the continuum of care consistent with Initial Standardized Assessment Protocol assessment and acceptable standards of care.

An evaluation protocol will continue to track consumers while they are engaged in treatment and after discharge to ensure that programs are demonstrating their treatment is effective and leads to recovery. Treatment effectiveness will be measured by seven outcome domains, including: 1) retention in treatment; 2) abstinence from alcohol and drug use; 3) no involvement with the criminal justice system; 4) attainment of employment or enrollment in school; 5) stable family and living conditions; 6) access and capacity to treatment; and, 7) involvement in the social supports of recovery.

All data collected to meet reporting requirements and conduct longitudinal outcome evaluation will be incorporated into the Customer Information Management, Outcomes, and Reporting (CIMOR) system. All service providers will be required to collect and enter this information into the CIMOR system. The Missouri Institute of Mental Health will continue to serve as the contractor to collect data for the Access to Recovery project.

The Global Assessment of Individual Needs (GAIN) assessment instrument will continue to be utilized across all adolescent CSTAR programs in FY 2008. Training and maintenance support of this assessment will be provided by provider and ADA GAIN-certified local trainers.

Missouri

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 16-18, 2005 with 747 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma informed care and cultural and linguistic competence, criminal justice, ethics, treatment planning for successful community outcomes, effective models for prevention in the treatment setting, and others.

The Division of Alcohol and Drug Abuse (ADA) treatment staff continued to provide a series of training modules that were delivered to treatment and prevention providers throughout the state. These sessions were tailored to meet the needs of the staff in each agency. On-site workshops were conducted during this fiscal year including Motivational Interviewing, Documentation, Treatment Planning, Confidentiality and Alcohol and Drug Federal Regulations, Addiction Ethics, Peer Review, Collaborative Model, and Outcomes Web Assessment. Regional Collaborative Model training provided initial cross-training opportunities for ADA and DHSS contracted providers. Staff was provided with regional epidemiological data and risk reduction methods to address consumer health risk factors associated with HIV/AIDS, STDs, TB, and hepatitis. Regional collaboration plans were developed as a direct result of these trainings to identify the health related training needs of their communities.

ADA continued to contract with Development Systems, Inc. to provide five regional HIV pre- and post-test counseling trainings to substance abuse provider staff. The Missouri Department of Health and Senior Services reviewed this curriculum and found it to meet the federal guidelines established by the Centers for Disease Control and Prevention.

ADA provided training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders. The training focus included community assessments, capacity building, and measurable outcomes. ADA also provided training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance was provided to promote community development, accountability, and targeted prevention initiatives based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. ADA consistently collaborated with CSAP's Southwest Center for the Application of Prevention Technology to provide training and technical assistance for targeted prevention initiatives.

FY 2007 (Progress)

The Department of Mental Health's annual Spring Training Institute was held May 16-18, 2007 and attended by over 1,100 professionals from the substance abuse prevention, substance abuse treatment, and mental health fields. The theme of the conference was, "Strengthening Families, Enhancing Lives". National and local experts shared information about a wide range of evidence-based practices including, trauma informed care and disaster situations, national outcomes measures, cognitive-behavioral treatment issues, medication assisted treatment, fetal alcohol spectrum disorders, motivational interviewing, faith-based treatment practice, and Missouri's methamphetamine problems. The Missouri Division of Alcohol and Drug Abuse (ADA) Clinical Services Team provided technical assistance and training sessions to treatment providers including ethics, implementation of the Consumer Information Management, Outcomes, and Reporting (CIMOR) system, accessing services, the certification process and documentation.

ADA Access To Recovery (ATR) staff developed a series of trainings that were presented to Missouri's clinical treatment and recovery support providers, with sessions tailored to meet the needs of the staff in each agency. ATR staff conducted 11 on-site training sessions during the fiscal year including: Government Performance and Results Act (GPRA) interview tool, ATR Overview, ATR Voucher Management, Clinical Supervision, Confidentiality, Ethics, and Motivational Interviewing. ADA/ATR staff has also completed 43 on-site technical assistance visits at the recovery support agencies. These visits included one-on-one training on documentation, proper invoicing techniques, ATR voucher management, and improving business practices.

ADA continued to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance concerning community development, accountability, and targeted prevention initiatives were based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. ADA has continued its close collaboration with Southwest Center for the Application of Prevention Technology (SWCAPT) to provide training and technical assistance for targeted prevention initiatives. The SWCAPT was designated to provide technical assistance to the Workforce Development Committee, known as the Missouri Prevention Network, to identify core competency requirements for levels of certification for prevention professionals. The SWCAPT also provided technical assistance to support the implementation of the Strategic Prevention Framework State Incentive Grant (SPFSIG). The SWCAPT position was filled in FY 2007. ADA regional prevention specialists provide technical assistance and training to the Missouri School-based Prevention Intervention Resources Initiative (SPIRIT) programs to assist with their implementation of science-based interventions.

Regional Collaborative Model cross-training was continued in partnership with the Department of Health and Senior Services (DHSS) to reduce incidence of blood borne and sexually transmitted diseases among ADA clientele. All regions received hepatitis

training and updated hepatitis curricula in the fall of 2006 to strengthen their capacity to reduce the spread of blood borne and sexually transmitted diseases.

ADA has collaborated with the DHSS to provide regional HIV pre- and post-test counseling trainings to substance abuse provider staff. The DHSS will provide materials and training curriculum as identified by the Centers for Disease Control and Prevention. Under the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project initiative with the DHSS, selected women and children's Comprehensive Substance Treatment and Rehabilitation (CSTAR) providers were trained to provide the Healthy Balance Intervention model of risk reduction to participating female consumers and to conduct screening for FAS. Continued in-service training for screening of FAS children has been provided to the staff of each participating CSTAR provider.

FY 2008 (Intended Use)

The Department of Mental Health's annual Spring Training Institute will be held May 14-16, 2008. Continued collaboration with the Mid-America Addiction Technology Transfer Center, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention will ensure that employees of treatment and prevention agencies in Missouri receive training and education to promote the use of evidence-based practices. Division of Alcohol and Drug Abuse (ADA) Access to Recovery (ATR) staff will continue to provide training to the clinical treatment and recovery support providers throughout the state. In the coming year, this training will consist of technical assistance visits at each of the new provider locations. These on-site trainings will include proper documentation and invoicing techniques as well as provide information on appropriate business practices. ADA/ATR staff will continue to partner with Committed Caring Faith Communities (CCFC), an independent statewide 501(c)(3) interfaith corporation, in presenting the Addictions Academy which is designed to educate recovery support providers on best practices in the field of addiction counseling and the faith communities' role in helping consumers recover. Training on the Government Performance and Results Act (GPRA) and the ATR voucher management system will be available to both clinical and recovery support providers upon request.

ADA will continue to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance will be focused on community development, accountability, and targeted prevention initiatives and will follow CSAP's best practices program recommendations. The Southwest Center for the Application of Prevention Technology (SWCAPT) will continue to provide technical assistance to ADA to support the implementation of Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as prevention providers and community coalitions implement their evidence-based programs. ADA will provide training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders to support their capacity to respond to community level prevention efforts supported with SPFSIG. ADA regional prevention staff will continue to provide technical assistance and training to the School-based Prevention Intervention Resources Initiative (SPIRIT) programs to encourage their utilization of best practice and science-based intervention services. The ADA Clinical Services Team will continue to provide technical assistance and trainings to providers and agencies within the community.

ADA will continue to collaborate with the Department of Health and Senior Services (DHSS) to provide HIV pre- and post-test counseling training to substance abuse provider staff. The training curriculum will continue to meet the federal guidelines of the Centers for Disease Control and Prevention. The Collaborative Model Initiative, in partnership with the DHSS, will be continued with provision of region specific technical assistance to reduce the incidence of sexually transmitted and blood borne diseases. Regional action plans will be utilized to identify the specific training and technical assistance needs of each region. Continued cross-training will be provided in

partnership with DHSS to promote provider collaboration and strengthen service delivery.

Under the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project initiative with the DHSS, selected women and children's Comprehensive Substance Treatment and Rehabilitation providers will continue to receive training and technical assistance to provide the Fetal Alcohol Syndrome (FAS) model of risk reduction, "Healthy Balance", to participating female consumers, and to effectively conduct screening for FAS at the five participating Women and Children CSTAR sites. This will be the final year of funding for the FAS grant.

Missouri

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate ,prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

Treatment services are coordinated with prevention activities and other appropriate services in the following manner:

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), is established by State Statute and is an advisory body to the Director of ADA and its director. The SAC is comprised of 25 members appointed by the ADA director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services and no more than one-fourth can be ADA treatment or prevention contract providers. The SAC collaborates with ADA in developing a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol and other drug abuse. The SAC reviews current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public treatment programs, and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding.

The following certification standards contribute to the coordination of treatment services. Certification standard 9 CSR 10-7.010 Treatment Principles and Outcomes states "(7) (A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.
2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.
3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.
4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.
5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals."

Adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) program

certification standard 9 CSR 30-3.192 (3) (F) requires: “Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that the needs of youth in treatment are met and that services are coordinated. Coordination of service needs is critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas.” Coordination of education for adolescent consumers during treatment is required by standards. All consumers in CSTAR programs are offered a community support worker whose responsibilities include “activities with or on behalf of a particular consumer in accordance with an individual rehabilitation plan to maximize the consumer’s adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting consumer independence and responsibility.” The community support worker arranges, refers, and monitors services external to the CSTAR program.

Each CSTAR Women and Children's program is required to provide a child care and development program for the children of women who are concurrently receiving treatment. Each center, as required in certification standards, must design appropriate services that address the following goals: building self esteem; learn to identify and express feelings; build positive family relationships; develop decision making skills; understand chemical dependency as a family illness; and learn and practice non-violent ways to resolve conflict. Each child receives an individual assessment to determine his/her needs, and appropriate intervention or referral is arranged. Children can receive individual and family therapy and group codependency counseling from qualified personnel. The mothers receive extensive weekly training on parenting skills and supervised parent/child bonding time to practice the new skills. The women and their children receive residential support or supportive housing to assure a safe drug free environment.

All women and children who enter treatment are provided health screenings by registered nurses to identify health deficits or needs for medical intervention. Close association with local health clinics provides prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. For women receiving day treatment and outpatient services, transportation is available to and from the facility. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers’ addiction.

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Department of Health and Senior Services (DHSS) to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. ADA continued to work with the DHSS to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed

HIV, TB, STD, and hepatitis risk assessments for all consumers. High risk consumers were provided pre-test counseling, testing referral, and post-test counseling services. ADA designated staff serve as liaisons with DHSS and ADA contracted treatment providers to respond to incidents or questions and to provide assistance with dissemination of infectious disease information.

ADA continued to work collaboratively with the DHSS on the Fetal Alcohol Syndrome (FAS) prevention initiative identified as the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP). ADA developed and provided training to the five participating Women and Children's CSTAR programs. The training included fundamentals of Motivational Interviewing and instructions for providing the Healthy Balance Intervention Strategy to eligible women receiving treatment in the five CSTAR programs. Additional educational FAS curriculum was also developed for use within the participating CSTAR sites for consumer education. Public awareness strategies and materials were also prepared to promote implementation of this program.

ADA continued support for the Missouri School-based Prevention and Intervention Initiative (SPIRIT) in the existing five school sites in Missouri, with one site located in each of the five ADA sub-state regions. The Missouri SPIRIT program continued to provide evidence-based prevention programs to students in grades K-12 using universal, selective, and indicated preventive interventions. The curriculums used in the SPIRIT initiative included Positive Action, Life Skills Training, Peace Builders, and Reconnecting Youth. Outcome measurement included use of the Teacher Observation Checklist (K-3), the Fidelity and Quality of Program Implementation Report, a revised Healthy Kids Survey (grades 4-5), the SPIRIT Survey for (grades 6-12), and the Youth Satisfaction Survey.

FY 2007 (Progress)

Missouri was awarded an Access to Recovery (ATR) Grant, in 2004 that provides $7.6 million per year for three years to implement a statewide treatment voucher system. Funding from this grant improved coordination and available alternatives among an increased number of qualified service providers; provided recovery support services through traditional, non-traditional, and faith-based organizations; and expanded the existing managed care system. Faith organizations and other nontraditional providers interested in providing recovery support services under the ATR project are required to become credentialed which requires participation in a 32-hour Addictions Academy. ADA is also currently reviewing the system of care for individuals with co-occurring psychiatric and substance use disorders as part of the Co-Occurring State Incentive Grant. Six agencies are collaborating on this project.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by State Statute and is an advisory body to ADA and the ADA director. The SAC is comprised of 25 members appointed by the ADA Director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services, and no more than one-fourth can be ADA treatment or prevention vendors. The SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends specific methods, means, and procedures to be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding. During FY2007, the SAC established a Treatment and a Prevention subcommittee to collaborate with appropriate ADA staff, provide feedback and provide suggestions into the planning and budget process for ADA activities.

Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standards continue to require ADA and contracted treatment and prevention providers to maintain effective working relationships with other community resources to meet the emotional, mental, physical and spiritual needs of consumers. ADA has provided numerous technical assistance visits and statewide meetings of providers to facilitate creative collaborative relationships with community resources. Two CSTAR programs continue the joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. ADA continues to collaborate with

DOC on their Missouri Reentry Program which was initiated with the Transition from Prison to Community Project. The primary objective of this program is to assist transitioning offenders with effective linkages to community treatment and mental health resources.

The Division of ADA and contracted providers have continued to be actively involved in disease prevention activities in collaboration with the Department of Health and Senior Services (DHSS) which include screening, risk reduction assessment and education, and treatment of active diseases. The third phase of regional collaborative model cross-training for contracted prevention and substance abuse providers and regional community health prevention and care staff was provided during the fall of 2006. Regional action plans directed the focus of this training to be the prevention of Hepatitis C and risk reduction intervention strategies. Subsequent regional training and technical assistance will be provided as staff training needs are identified.

The Division of ADA has continued to partner with DHSS to coordinate the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP), a five-year prevention initiative funded by the Centers for Disease Control and Prevention (CDC) to focus Fetal Alcohol Syndrome Disorder prevention services in rural counties. The participating CSTAR programs received implementation training in August 2006 and began provision of the Healthy Balance Intervention model at that time. The CDC grant includes funding for a second year of training to support the use of the FAS prevention intervention strategy “Healthy Balance”. This training has been scheduled for August 2007 and will include Motivational Interviewing skill development and technical assistance designed to encourage program model fidelity. The CSTAR programs have also been providing FAS screening to the children of mothers who are receiving substance abuse treatment.

The Division of ADA has continued the Missouri School-based Prevention and Intervention Initiative (SPIRIT). The Missouri SPIRIT program provides evidence-based prevention programs to 5,217 students in grades K–12. The curricula used are Positive Action, Life Skills Training, Peace Builders, 2 Good 4 Drugs, Second Step, and Reconnecting Youth. Prevention providers assist school personnel with identification and screening of students exhibiting problem behaviors. Missouri SPIRIT objectives are to delay onset of chemical use, decrease substance use, improve overall school performance, and reduce violence. The Missouri Institute of Mental Health has continued to provide program evaluation, collecting three types of data: individual, school or group, and program fidelity. In order to participate in the evaluation, both parental consent and student assent are required. A total of 3,675 students participated in the evaluation during FY 2007. The following measures continue to be used: Teacher Observation Checklist (K-3), SPIRIT Fidelity and Quality of Program Implementation Report, Healthy Kids Survey (grades 4-5), and the SPIRIT Survey (grades 6-12). Additional data collected on individual students includes grades, achievement test results, school attendance, suspensions, violent incidents, race, age, and gender. School level data serve as indicators for each grade as a whole regardless of student participation in the evaluation.

In FY 2007, Missouri had its Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan approved. The SPF SIG team provided training to the Regional Support Centers and SPF SIG recipients on developing their strategic plans. All 18 SPF SIG coalitions completed their initial strategic plans on March 15th. All 18 coalitions had been granted continued funding for their projects, although some plans required revisions. SPF SIG staff provided training and technical assistance to the SPF SIG recipients to help them with assessment and the creation of baseline measures. State-level SPF SIG staff and Chuck Daugherty, Missouri's SWCAPT representative, also provided individual technical assistance at the trainings and at follow-up site visits. Missouri's state priority under this grant is to reduce risky drinking for persons aged 12-25 years.

The State Epidemiological Workgroup (SEW) completed a needs assessment on Missouri's substance abuse issues for the SPF SIG Governor's Advisory Committee in June 2006. The SEW assisted with the state strategic plan and training of the coalitions.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to require coordination of substance abuse treatment with community resources to provide additional recovery support services to meet the needs of consumers. Housing, transportation, vocational rehabilitation, education and family services will continue to be addressed in Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. Specialized programs will continue to provide treatment for adolescents, the opiate addicted, pregnant women, and women with dependent children. These programs provide additional programming and also maintain collaborative relationships with external community agencies to provide recovery support services to meet the special needs of these populations. The Co-Occurring State Incentive Grant project will continue to identify and implement system changes to meet the needs of consumers with co-occurring disorders and improve the integration of substance abuse treatment with existing mental health services.

Missouri has submitted an application for Access to Recovery II grant funding to continue the system gains achieved in Access to Recovery. System enhancements in ATR II will include coordination of Faith Based Recovery Support providers to emphasize the use of recovery supports during pretreatment or in less intense levels of out patient care. Recovery support services will also be expanded to availability to consumers being discharged from correctional facilities to help bridge the transition between institutional life and community based substance abuse treatment. Recovery support will also be expanded to include consumers enrolled in CSTAR Women and Children programs.

An Office of Faith Based and Community Partnerships was established in March of 2007. The duties of this office will be to coordinate the efforts of faith based recovery support providers with substance abuse treatment and prevention providers and ADA staff.

The Division of ADA and contracted providers will continue to be involved in collaborative disease prevention activities with the Department of Health and Senior Services (DHSS) including screening, risk reduction, assessment, education, and treatment of active diseases. Continued regional collaborative trainings will be planned to support the use of timely epidemiological data and to strengthen collaborative partnerships between ADA and DHSS providers.

The Division of ADA will continue its collaborative partnership with DHSS to continue to support the Missouri Fetal Alcohol Syndrome (FAS) Rural Awareness and Prevention Project funded by the Centers for Disease Control and Prevention. This will be the last year of funding for this grant for implementation of the Healthy Balance and FAS screening. The Healthy Balance prevention intervention model will continue to be made available to women receiving substance abuse treatment services in five Women and Children CSTAR programs, and staff will continue to provide FAS screening for the children of their consumers.

The Division of ADA will continue to provide funding for program implementation and evaluation at the five School-based Prevention and Intervention Initiative (SPIRIT) sites. Evaluators will continue to track the number of referrals made through the project. Performance measures will include the Teacher Observation Checklist, the California Healthy Kids Survey, the Missouri Student Survey and Supplemental Survey, the SPIRIT Fidelity and Quality of Program Implementation Report, the Youth Satisfaction Survey, and the teacher responses obtained from the SPIRIT Initiative Questionnaire. In collaboration with the Missouri Department of Elementary and Secondary Education, ADA will continue to support the Internet-based administration of the Missouri Student Survey in all Missouri school districts. Local districts and ADA will continue to use survey results for planning and program development. ADA will seek additional funding to increase the number of SPIRIT program sites during the next fiscal year.

The State Epidemiological Workgroup (SEW) will finish creating a Learning Community model for providing prevention data to stakeholders at multiple levels, from community to mid-level managers, administrators, and policy makers. Within a few months, all of the Strategic Prevention Framework State Incentive Grant (SPF SIG) coalitions will be in the implementation phase, laying the groundwork for their evidence-based program and environmental strategy kickoffs. The SPF SIG Governor's Advisory Committee will continue to review the goals contained within our state strategic plan.

Missouri

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The treatment needs estimates provided in Forms 8 and 9 originated in one of the reports from Missouri's second State Treatment Needs Assessment Program (STNAP-II) funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, under CSAT Grant No. 5H79 TI12229. The data in Forms 8 and 9 were published as supplemental tables in the report *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*, RTI International, September 2003. The tables were requested by the Missouri Division of Alcohol and Drug Abuse expressly to prepare the FY2005 SAPT Block Grant Application and subsequent applications. RTI International formatted the tables to match Forms 8 and 9 (OMB No. 0930-0080). The Form 8 table provided treatment needs estimates for each ADA Region and Service Area for the total population, IV drug users, and women based on the STNAP-II needs assessment rates for demographic groups. The tables for Form 9 provided breakouts of the total population treatment needs estimates for each Region by age group, race (White and All Other), and gender. The treatment needs estimates were used to estimate treatment penetration rates, plan and allocate treatment services, and develop the ADA portion of the Department of Mental Health's annual budget request. The estimates were also summarized in the *Status Report on Missouri's Alcohol and Drug Abuse Problems--11th Edition* (Department of Mental Health, April 2005).

During FY 2005, ADA prepared to replicate the SmartTrack web-application for the 2006 Missouri Student Survey. The survey was developed to measure substance abuse incidence and prevalence and risk and protective factors among public school students in all 524 Missouri school districts in grades 6-12. The survey provided district-level and statewide data for prevention planning requirements. ADA contracted with the Missouri Institute of Mental Health to collect the data and develop a report to analyze trends in substance abuse, delinquent behavior, and risk and protective factors.

The School-based Prevention and Intervention Initiative (SPIRIT) second year report was published in spring 2005. SPIRIT was developed to delay onset and decrease use of substances, improve overall school performance, and reduce school-related violent incidents. Three classifications of data--individual, school, and program fidelity--were collected from 1,287 students.

The Division of ADA continued to develop a systematic, data driven approach to estimate statewide and regional prevention needs. In FY 2005, ADA (and the Governor's Office) was awarded the Strategic Prevention Framework State Incentive Grant to provide funding for community coalitions to plan and implement data-driven prevention projects. That application was approved for CSAP funding through Grant No. 1 U79 SP11194-01 awarded in FY 2005. Missouri began the steps of the Strategic Prevention Framework, including developing a Governor's Advisory Committee for the Grant.

FY 2007 (Progress)

The treatment needs estimates provided in Forms 8 and 9 originated in one of the reports from Missouri's second State Treatment Needs Assessment Program (STNAP-II) funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, under CSAT Grant No. 5H79 TI12229. The data in Forms 8 and 9 were published as supplemental tables in the report *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*, RTI International, September 2003. The tables were requested by the Missouri Division of Alcohol and Drug Abuse expressly to prepare the FY2005 SAPT Block Grant Application and subsequent applications. RTI International formatted the tables to match Forms 8 and 9 (OMB No. 0930-0080). The Form 8 table provided treatment needs estimates for each ADA Region and Service Area for the total population, IV drug users, and women based on the STNAP-II needs assessment rates for demographic groups. The tables for Form 9 provided breakouts of the total population treatment needs estimates for each Region by age group, race (White and All Other), and gender.

In 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2003-2004 National Survey on Drug Use and Health (NSDUH). Due to the availability of the NSDUH state data, ADA updated the prevalence estimates in Forms 8 and 9. The updates reflected 1) population changes that occurred between Census 2000 (the population base used in the STNAP-II study) and the 2004 Census estimates, and 2) the new NSDUH estimates for Missouri developed by SAMHSA's Office of Applied Studies. ADA used the estimated number of individuals with "alcohol or illicit drug dependence or abuse" as the measure of treatment need. The population adjustments in the STNAP-II estimates and the prevalence estimates by age group from the NSDUH were combined to produce a new set of treatment needs estimates for the ADA service areas and planning regions by age group, race/ethnicity, and gender. In 2007, SAMHSA released national and state estimates from the combined 2004-2005 National Survey on Drug Use and Health. ADA again updated the treatment needs estimates in Forms 8 and 9, using the methodology identified above and the 2005 Census estimates.

The updated estimates were used to calculate treatment penetration rates; plan and allocate treatment services; prepare presentation materials for the state legislature and other policy makers; and develop the Division of Alcohol and Drug Abuse (ADA) portion of the Department of Mental Health's annual budget request for SFY 2009. The estimates were also summarized in the *Status Report on Missouri's Alcohol and Drug Abuse Problems--13th Edition* (Department of Mental Health, April 2007).

The Missouri Department of Elementary and Secondary Education (DESE) and ADA continued to collaborate in supporting and promoting the Missouri Student Survey, an instrument that collects data on substance abuse incidence and prevalence; delinquent behavior; and risk and protective factors related to a range of health and safety issues. In the spring of 2006, ADA made the survey available over the internet to secondary school students in Missouri's 524 school districts using the SmartTrack application.

ADA continued to develop a systematic, data driven approach to identify statewide and regional prevention needs using data from this survey and other assessments. A final report of the Missouri's 524 secondary school districts' 2006 survey was published in December 2006.

The Missouri Governor's Prevention Initiative completed the state's Strategic Prevention Plan and submitted it to the Center for Substance Abuse Prevention (CSAP) for review. It was approved in FY 2006. The plan integrated results from three reports initiated under the Governor's Substance Abuse Prevention Initiative planning grant (SAMHSA Grant #1 UD1 SP10384-01) and the State Epidemiological Workgroup Initial Needs Assessment completed under the Missouri Strategic Prevention Framework State Incentive Grant (SPF SIG, SAMHSA Grant #1 U79 SP11194-01). Eighteen coalitions were awarded SPF SIG funding and have been working on their strategic plans. They were first awarded six-month planning contracts of up to $45,000 to complete the first three requirements of the SPF SIG (assessment, capacity building, and planning) and then followed by additional program implementation funding, with a maximum $125,000 per year for three years available for each site for prevention program planning and implementation.

In December 2006, ADA published the fourth-year report of its SPIRIT initiative. The evaluation component of SPIRIT uses three instruments to measure the progress of children and youth as a result of the program. Children in grades K-3 are assessed by teachers using a form that measures changes in aggression and social skills. Students in grades 4–5 complete an approved, localized version of the California Healthy Kids Survey, which assesses risk and protective factors related to adolescent substance use. Students in grades 6–12 complete the SPIRIT Survey, which is an adaptation of the Missouri Student Survey and measures substance use, family management, stress management, decision making, self-esteem, perceived risk of using substances, frequency of anti-social behavior, and attitudes toward substance use. Additional data are collected on students in grades 4–12 including grades, disciplinary incidents, school attendance, race, age, and gender. The fourth-year report presented data from 1,581 students.

FY 2008 (Intended Use)

The treatment needs estimates provided in Forms 8 and 9 originated in one of the reports from Missouri's second State Treatment Needs Assessment Program (STNAP-II) funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, under CSAT Grant No. 5H79 TI12229. The data in Forms 8 and 9 were published as supplemental tables in the report *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*, RTI International, September 2003. The tables were requested by the Missouri Division of Alcohol and Drug Abuse expressly to prepare the FY2005 SAPT Block Grant Application and subsequent applications. RTI International formatted the tables to match Forms 8 and 9 (OMB No. 0930-0080). The Form 8 table provided treatment needs estimates for each ADA Region and Service Area for the total population, IV drug users, and women based on the STNAP-II needs assessment rates for demographic groups. The tables for Form 9 provided breakouts of the total population treatment needs estimates for each Region by age group, race (White and All Other), and gender.

In 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2003-2004 National Survey on Drug Use and Health (NSDUH). Due to the availability of the NSDUH state data, ADA updated the prevalence estimates in Forms 8 and 9. The updates reflected 1) population changes that occurred between Census 2000 (the population base used in the STNAP-II study) and the 2004 Census estimates, and 2) the new NSDUH estimates for Missouri developed by SAMHSA's Office of Applied Studies. ADA used the estimated number of individuals with "alcohol or illicit drug dependence or abuse" as the measure of treatment need. The population adjustments in the STNAP-II estimates and the prevalence estimates by age group from the NSDUH were combined to produce a new set of treatment needs estimates for the ADA service areas and planning regions by age group, race/ethnicity, and gender. In 2007, SAMHSA released national and state estimates from the combined 2004-2005 NSDUH. ADA again updated the treatment needs estimates in Forms 8 and 9 with the methodology used in the 2006 updates and the 2005 Census estimates. ADA anticipates that in 2008 SAMHSA will release state estimates from the combined 2005-2006 NSDUH. When the Missouri data becomes available, ADA will again update Forms 8 and 9 using the methodology identified above.

The updated estimates of treatment need will be used to calculate treatment penetration rates; plan and allocate treatment services; prepare presentation materials for the state legislature and other policy makers; and develop the Division of Alcohol and Drug Abuse (ADA) portion of the Department of Mental Health's annual budget request for SFY 2010. The estimates will also be summarized in the *Status Report on Missouri's Alcohol and Drug Abuse Problems--14th Edition,* planned for publication in April 2008.

Funds have been allocated for program implementation under the Strategic Prevention Framework State Incentive Grant (SPF SIG). Sub-recipients funded through the SPF SIG will continue to work on their strategic plans in which they will assess needs, resources, and readiness at the community level as part of their planning process. The

state's priority issue of risky drinking among young people ages 12-25 will be addressed through various evidence-based programs. National outcome measures specific to local prevention projects will continue to be collected at the community level. ADA will continue to plan for the biennial Missouri Student Survey which will next be conducted in the spring of 2008. The survey will be available online to all of Missouri's school districts. ADA will continue to collect data on the progress of students participating in the School-based Prevention and Intervention (SPIRIT) initiative.

Missouri

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) has continued the policy ensuring no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. ADA's contracts with treatment providers state: "The contractor agrees and understands that payments received under the contract SHALL NOT be expended in the following manner: to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection."

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways: three year Certification Survey's, Annual Safety and Basic Assurances Reviews and periodic site visits by the District Administrators and Area Treatment Coordinators.

FY 2007 (Progress)

The Division of Alcohol and Drug Abuse (ADA) has continued the policy ensuring that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways: three year Certification Survey's, Annual Safety and Basic Assurances Reviews and periodic site visits by the District Administrators and Area Treatment Coordinators.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue the policy ensuring that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Contract providers will continue to be required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy will be ensured through: three year Certification Survey's, Annual Safety and Basic Assurances Reviews and periodic site visits by the District Administrators and Area Treatment Coordinators.

Missouri

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment and services provided. Seven independent peer reviews were conducted in FY 2005. The contracts for treatment providers require that they make staff available to perform peer reviews of other agencies in the state.

Peer Review Contract Language:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

FY 2007 (Progress)

The Division of Alcohol and Drug Abuse (ADA) facilitated eight peer reviews for FY 2007. Reviews were conducted in each region of the state and generally involve providers from different regions. The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the District Administrator, the agency being reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to facilitate independent peer reviews to encourage and assess the quality, appropriateness and efficacy of the substance abuse treatment being provided. Peer reviews will be scheduled annually in each region of the state. Area Treatment Coordinators will be responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report will be distributed to the District Administrator, the agency being reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator will review the report with the appropriate agency staff.

Missouri

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2006 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the Single State Authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

Attachment H

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment services provided. ADA has been contractually requiring all treatment providers to participate in independent peer review since July 1993. Contracted providers have been cooperating with this requirement each year since that time. Seven reviews were conducted in FY 2003, FY 2004, FY 2005, and FY 2006. Eight reviews were conducted in FY 2007.

The contract between ADA and the treatment provider includes language which requires each provider to participate in the peer review process. The contract states:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the District Administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

The agency being reviewed cooperates by providing access to consumer records, staff and policy and procedures documents. The reviewer utilizes this information to

establish the agency's compliance with certification standards, best practices and efficacy in operations. The reviewer has an opportunity to learn from another program's operations. The information is also useful to the ADA's treatment specialists and other staff that provide monitoring and technical assistance to the agencies statewide. In addition to contract compliance, the role of the Area Treatment Coordinator is to conduct safety and basic assurances monitoring, provide technical assistance, and/or arrange for technical assistance visits. Some of the feedback provided through the peer review process includes suggestions regarding treatment planning, documentation, cultural diversity, and agency systems improvement.

Federal confidentiality regulations are observed throughout the individual peer review process. All members of the peer review team are knowledgeable of, and agree to comply with, federal confidentiality regulations in carrying out their assigned duties.

In Summary, the role of ADA in Peer Reviews is as follows:

1. Providers are contractually bound to participate in Peer Reviews by ADA contracts;
2. The Area Treatment Coordinators initiate the Peer Review;
3. The Area Treatment Coordinators assure that the Peer Reviewer is a knowledgeable and experienced Substance Abuse Treatment Professional;
4. The Area Treatment Coordinators assure the findings and recommendations of the Peer Review visit are reported in a timely fashion;
5. The Area Treatment Coordinators review the findings and recommendations report;
6. The District Administrator reviews the findings and recommendations of the Peer Review report;
7. The District Administrator and Area Treatment Coordinator review the report with the appropriate audited agency staff and provide technical assistance.
8. The District Administrator reviews significant deviations from contractually requirements or Certification Standards with the Executive Director of the audited agency;
9. The District Administrator may review reoccurring problems with the ADA Division Director;
10. The District Administrator and Area Treatment Coordinator will utilize positive findings of innovative practices in technical assistance visits to all providers to spread improvements in clinical practice;
11. Copies of Peer Review findings and Recommendations are filed with the agencies certification file.

Missouri

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. Part 2).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) has complied with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and, as of April 2003, the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complied with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also required contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance have been provided to contracted program staff to ensure compliance with the federal regulations. ADA monitors the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurances Reviews and periodic site visits by District Administrators and Area Treatment Coordinators.

FY 2007 (Progress)

The Division of Alcohol and Drug Abuse (ADA) continued to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complies with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also requires contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. All new ADA employees received orientation and training to division policy and the above sited confidentiality laws. Training and technical assistance continue to be provided to contracted program staff to ensure compliance with the federal regulations. ADA continues to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by Dsitrict Administrators and Area Treatment Coordinators.

FY 2008 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA will continue to require contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance will continue to be provided to contracted program staff to ensure compliance with the federal confidentiality regulations. ADA will continue to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurances Reviews and periodic site visits by District Administrators and Area Treatment Coordinators.

Missouri

Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions and Regulations).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

FY 2005 (Compliance)

Not Applicable

FY 2007 (Progress)

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services requires that those agencies comply with Block Grant Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract providers are required to follow the above procedures. There are 120 contracted treatment providers in Missouri of which two have identified themselves as being faith-based organizations. The number of recovery support providers contracting with ADA has increased dramatically over the past year. Currently, there are 107 recovery support providers of which 91 have identified themselves as faith-based organizations. Programs currently certified by ADA to provide clinical substance abuse treatment services are not eligible to be recovery support providers. Faith-based organizations desiring to provide recovery support services must be credentialed by the ADA and the Committed Caring Faith Communities, an independent statewide not-for-profit 501(c)(3) interfaith corporation. Nontraditional service providers desiring to provide recovery support services through the Access to Recovery (ATR) project must be credentialed by ADA.

Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Treatment and recovery support decisions are made with the participation of and in collaboration with consumers and treatment providers. Consumers are provided with recovery support vouchers that allow for charitable choice and authorize services as a result of consumer-requested referrals to faith-based and non-traditional organizations. There were no such consumer-requested referrals from contracted treatment providers. Since program implementation there have been six consumers who made charitable choice decisions from “Saved to Serve,”

a faith-based recovery support provider, to other recovery support providers. There were no such decisions and consequent referrals made in FY 2007.

Guidelines, training and technical assistance have been made accessible to providers. An application process to become an ATR provider was implemented which includes participation in the Addictions Academy (a 32-hour training program that integrates charitable choice requirements). Personnel designated specifically for this program perform oversight and audits of programs and services.

FY 2008 (Intended Use)

The Missouri Code of State Regulations will continue to require that individuals not be denied admission or receive services based on creed. The right of an individual to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services will continue to require those agencies to comply with the Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

The Division of ADA will continue to develop resources that involves traditional, non-traditional and faith based organizations interested in providing recovery support services under the Access to Recovery (ATR) project. Recovery support providers will continue to allow charitable choice in substance abuse treatment services to consumers through the voucher process. Continuing training, certification and monitoring will ensure the consumers have charitable choice and quality services. In addition, an entire track for faith-based programs was added to the ADA's Spring Training Institute. Charitable Choice requirements were included in the curriculum of the classes in this track.

Data collection has been and remains a requirement of the ATR project. All data collected to meet these requirements and to conduct longitudinal outcome evaluation is being incorporated into the Customer Information Management, Outcomes, and Reporting (CIMOR) system. All service providers are required to collect and enter this information into the CIMOR system. Once the data is entered, the Missouri Institute of Mental Health serves as the contractor to collect and report findings for the ATR project.

State:
Missouri

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2007) to the fiscal year for which the State is applying for funds provide a description of the State’s procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- ☒ Use model notice provided in final regulations.
- ☐ Use notice developed by State (attached copy).
- ☒ State has disseminated notice to religious organizations that are providers.
- ☒ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☒ State has incorporated this requirement into existing referral system(s).
- ☒ SAMHSA’s Treatment Facility Locator is used to help identify providers.
- ☒ Other networks and information systems are used to help identify providers.
- ☒ State maintains record of referrals made by religious organizations that are providers.
- ☒ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Missouri was awarded $22.8 million over three years to implement a statewide voucher system for adults that affords genuine, free and independent choice among an increased number of qualified service providers; provides recovery support services through traditional, non-traditional and faith-based organizations; expands the existing managed care system for proper control and monitoring; and measures outcomes in seven critical domains. Faith organizations and other nontraditional providers interested in providing recovery support services under the Access to Recovery project are required to have a minimum of two staff or volunteers complete the Addictions Academy which includes Charitable Choice requirements in this training. Additionally, ADA included a Faith Based provider track to its annual Spring Training Institute which was offered to clinicians from all disciplines and included Charitable Choice provisions in several of the course curriculum offered in this track.

State:
Missouri

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))

- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))

- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Missouri

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Missouri is not requesting any waivers.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Missouri

Dates of State Expenditure Period:
From 7/1/2005 to 6/30/2006

Activity	A. SAPT Block Grant FY 2005 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention* and Treatment	$19,727,123	$24,070,593	$8,726,591	$27,395,823	$	$
2. Primary Prevention	$5,342,923		$2,773,289	$331,531	$	$
3. Tuberculosis Services	$15,073	$7,690	$	$17,527	$	$
4. HIV Early Intervention Services	$	$48,514	$	$695,700	$	$
5. Administration (excluding program/provider level)	$1,246,035		$20,000	$1,365,245	$	$
6. Column Total	$26,331,154	$24,126,797	$11,519,880	$29,805,826	$	$

*** Prevention other than Primary Prevention**

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

Form 4ab

State:
Missouri

Form 4a. Primary Prevention Expenditures Checklist

	Block Grant FY 2005	Other Federal	State	Local	Other
Information Dissemination	**$605,183**	**$506,168**	**$5,927**	**$**	**$**
Education	**$2,252,393**	**$522,573**	**$10,287**	**$**	**$**
Alternatives	**$196,963**	**$489,620**	**$12**	**$**	**$**
Problem Identification & Referral	**$3,574**	**$**	**$**	**$**	**$**
Community-Based Process	**$782,261**	**$**	**$6,638**	**$**	**$**
Environmental	**$852,636**	**$830,455**	**$264**	**$**	**$**
Other	**$280,824**	**$424,473**	**$**	**$**	**$**
Section 1926 - Tobacco	**$369,089**	**$**	**$308,403**	**$**	**$**
TOTAL	**$5,342,923**	**$2,773,289**	**$331,531**	**$**	**$**

Form 4b. Primary Prevention Expenditures Checklist

	Block Grant FY 2005	Other Federal	State	Local	Other
Universal Indirect	**$1,402,366**	**$2,609,972**	**$331,531**	**$**	**$**
Universal Direct	**$2,394,407**	**$**	**$**	**$**	**$**
Selective	**$1,546,150**	**$163,317**	**$**	**$**	**$**
Indicated	**$**	**$**	**$**	**$**	**$**
TOTAL	**$5,342,923**	**$2,773,289**	**$331,531**	**$**	**$**

Form 4ab Footnotes
Other Federal: Safe & Drug Free Schools & Comunities - Enforcing Underage Drinking Laws Block Grant, EUDL Cimmunity Trials & SPF SIG.

State: Healthy Family Trust Fund (state tobacco settlement funds) & general revenue.

Form 4c

Resource Development Expenditure Checklist

State:
Missouri

Did your State fund resource development activities from the FY 2005 block grant?

☒ Yes ☐ No

	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$295,368**	**$**	**$295,368**
Quality Assurance	**$**	**$**	**$**	**$**
Training (post-employment)	**$32,925**	**$5,552**	**$**	**$38,477**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$**	**$151,193**	**$**	**$151,193**
Research and Evaluation	**$50,000**	**$342,227**	**$**	**$392,227**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$82,925**	**$794,340**	**$**	**$877,265**

Expenditures on Resource Development Activities are:

☒ **Actual** ☐ **Estimated**

SUBSTANCE ABUSE ENTITY INVENTORY

State:
Missouri

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
008	X	Central Region	$523,619		$158,782	$	$688,690	$
009	MO901642	Eastern Region	$458,740		$	$	$	$
021	MO102084	Northwest Region	$367,697		$12,837	$	$	$
037	MO750593	Southwest Region	$505,137		$264,217	$	$	$
037a	MO100907	Southwest Region	$81,595		$42,679	$	$	$
043	MO100948	Southwest Region	$201,238		$159,951	$	$67,890	$
043a	MO902004	Southwest Region	$47,716		$37,926	$	$16,098	$
045a	MO105244	Northwest Region	$107,500		$22,856	$	$	$
045b	MO102142	Northwest Region	$366,364		$77,894	$	$	$
045c	MO902608	Northwest Region	$63,017		$13,398	$	$	$
045d	MO902673	Northwest Region	$68,577		$14,580	$	$	$
048	MO101631	Southwest Region	$16,538		$3,018	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
049a	MO106614	Central Region	$16,324		$8,103	$	$953	$
049b	MO106218	Southeast Region	$55,669		$27,633	$	$3,251	$
049c	MO103801	Southwest Region	$74,922		$37,190	$	$4,376	$
049d	MO106259	Southwest Region	$3,767		$1,870	$	$220	$
049e	MO901527	Southwest Region	$371,682		$184,498	$	$21,708	$
049g	MO106309	Southwest Region	$71,155		$35,321	$	$4,156	$
049h	MO103272	Northwest Region	$28,462		$14,128	$	$1,662	$
049i	MO106242	Southwest Region	$42,275		$20,985	$	$2,469	$
049j	MO100404	Southeast Region	$40,182		$19,946	$	$2,347	$
049k	MO103207	Central Region	$161,146		$79,991	$	$9,412	$
049l	MO105814	Central Region	$15,487		$7,687	$	$905	$
049m	MO103298	Central Region	$22,602		$11,219	$	$1,320	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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049n	MO105798	Central Region	$47,716		$23,686	$	$2,787	$
049o	MO103124	Northwest Region	$62,784		$31,165	$	$3,667	$
049p	MO103280	Northwest Region	$186,678		$92,664	$	$10,903	$
049q	MO901543	Northwest Region	$113,849		$56,513	$	$6,649	$
049r	MO103231	Northwest Region	$37,252		$18,491	$	$2,176	$
049s	MO103215	Northwest Region	$50,646		$25,140	$	$2,958	$
049t	MO100321	Central Region	$53,994		$26,802	$	$3,154	$
049u	MO100892	Southwest Region	$3,767		$1,870	$	$220	$
049v	MO106283	Central Region	$17,998		$8,934	$	$1,051	$
049w	MO103918	Southwest Region	$50,227		$24,932	$	$2,934	$
049x	MO100865	Northwest Region	$15,068		$7,480	$	$880	$
049y	MO106234	Northwest Region	$12,975		$6,441	$	$758	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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049z	MO100808	Northwest Region	$60,691		$30,126	$	$3,545	$
052a	MO103389	Southwest Region	$37,567		$17,782	$	$	$
052d	MO901501	Southwest Region	$444,539		$210,423	$	$	$
052e	MO100869	Southwest Region	$13,566		$6,421	$	$	$
052f	MO100650	Southwest Region	$159,658		$75,574	$	$	$
052g	MO100787	Southwest Region	$39,654		$18,770	$	$	$
053a	MO102159	Central Region	$420,127		$202,758	$	$	$
053b	MO750064	Central Region	$253,688		$122,433	$	$	$
055a	MO903911	Southeast Region	$386,177		$123,913	$	$	$
055aa	MO100774	Southeast Region	$12,538		$4,023	$	$	$
055ab	MO105129	Southeast Region	$14,210		$4,560	$	$	$
055b	MO103785	Southeast Region	$54,750		$17,568	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
055c	MO104593	Southeast Region	$257,034		$82,475	$	$	$
055d	MO100771	Southeast Region	$5,851		$1,877	$	$	$
055e	MO100850	Southeast Region	$19,643		$6,303	$	$	$
055f	MO100848	Southeast Region	$18,807		$6,035	$	$	$
055g	MO104791	Southeast Region	$10,866		$3,487	$	$	$
055h	MO100859	Southeast Region	$55,168		$17,702	$	$	$
055i	MO105111	Southeast Region	$28,838		$9,253	$	$	$
055j	MO100860	Southeast Region	$20,897		$6,705	$	$	$
055k	MO100637	Southeast Region	$10,866		$3,487	$	$	$
055l	MO100929	Southeast Region	$9,195		$2,950	$	$	$
055m	MO100851	Southeast Region	$20,897		$6,705	$	$	$
055n	MO104791	Southeast Region	$12,120		$3,889	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
055o	MO100770	Southeast Region	$105,321		$33,794	$	$	$
055p	MO100858	Eastern Region	$42,212		$13,545	$	$	$
055q	MO100853	Southeast Region	$17,136		$5,498	$	$	$
055r	MO000122	Southeast Region	$62,691		$20,116	$	$	$
055s	MO100847	Central Region	$35,943		$11,533	$	$	$
055t	MO101433	Eastern Region	$50,153		$16,093	$	$	$
055u	MO105913	Southeast Region	$32,599		$10,460	$	$	$
055v	MO100719	Southeast Region	$29,674		$9,521	$	$	$
055w	MO100772	Southeast Region	$124,128		$39,829	$	$	$
055x	MO100852	Southeast Region	$50,153		$16,093	$	$	$
055y	MO100855	Southeast Region	$28,838		$9,253	$	$	$
055z	MO100854	Southeast Region	$54,750		$17,568	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
056a	MO101128	Southeast Region	$218,125		$301,858	$148,070	$34,914	$
056ac	MO101227	Southeast Region	$79,678		$110,264	$54,088	$12,754	$
056b	MO301793	Southeast Region	$444,160		$614,663	$301,511	$71,095	$
056c	MO101391	Southeast Region	$9,607		$13,294	$6,521	$1,538	$
056e	MO100620	Southeast Region	$6,216		$8,602	$4,220	$995	$
056f	MO000041	Southeast Region	$72,897		$100,880	$49,485	$11,668	$
056g	MO903598	Southeast Region	$7,911		$10,948	$5,370	$1,266	$
056h	MO105640	Southeast Region	$27,124		$37,537	$18,413	$4,342	$
057a	MO100872	Northwest Region	$386,553		$235,668	$235,668	$	$
057b	MO106010	Northwest Region	$9,612		$13,986	$	$	$
057c	MO101094	Northwest Region	$681,116		$415,253	$415,253	$	$
058a	MO100518	Northwest Region	$222,234		$273,632	$114,833	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
058b	MO301678	Northwest Region	$527,680		$649,724	$272,665	$	$
058c	MO100914	Northwest Region	$41,357		$50,923	$21,370	$	$
061a	MO101011	Central Region	$302,677		$263,239	$55,476	$	$
061b	MO103694	Central Region	$11,928		$10,374	$2,186	$	$
061c	MO106101	Central Region	$47,216		$41,064	$8,654	$	$
061d	MO750098	Central Region	$511,916		$445,215	$93,826	$	$
061e	MO106671	Central Region	$75,048		$65,269	$13,755	$	$
061f	MO105830	Southeast Region	$8,946		$7,780	$1,640	$	$
061g	MO750502	Southeast Region	$353,371		$307,328	$64,767	$	$
061h	MO105848	Southeast Region	$12,425		$10,806	$2,277	$	$
061i	MO100718	Central Region	$25,347		$22,045	$4,646	$	$
061j	MO100894	Southeast Region	$2,982		$2,593	$547	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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062a	MO902269	Central Region	$318,782		$512,263	$512,263	$	$
062b	MO100179	Central Region	$205,580		$115,182	$	$46,308	$
062c	MO105475	Central Region	$24,637		$13,804	$	$5,550	$
062d	MO750056	Central Region	$32,715		$18,330	$	$7,369	$
062e	MO100187	Central Region	$186,193		$104,320	$	$41,941	$
062f	MO100785	Central Region	$9,693		$5,431	$	$2,183	$
062g	MO100784	Central Region	$5,654		$3,168	$	$1,274	$
062h	MO104262	Central Region	$12,117		$6,789	$	$2,729	$
062i	MO105285	Central Region	$20,195		$11,315	$	$4,549	$
062j	MO100776	Central Region	$43,620		$24,439	$	$9,826	$
062k	MO100483	Central Region	$12,924		$7,241	$	$2,911	$
062l	MO102159	Central Region	$46,447		$26,023	$	$10,462	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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062m	MO100782	Central Region	$5,251		$2,942	$	$1,183	$
062n	MO103207	Central Region	$27,061		$15,161	$	$6,096	$
062o	MO100783	Central Region	$7,674		$4,300	$	$1,729	$
067a	MO301603	Eastern Region	$		$13,980	$	$	$
067b	MO100765	Eastern Region	$		$25,863	$	$	$
067c	MO900081	Eastern Region	$		$14,679	$	$	$
074a	MO103330	Northwest Region	$5,514		$291	$	$	$
074b	MO103348	Southwest Region	$2,981		$157	$	$	$
074c	MO100930	Southwest Region	$22,056		$1,162	$	$	$
082a	MO901592	Eastern Region	$447,120		$330,451	$	$	$
082b	MO103009	Eastern Region	$126,520		$93,507	$	$	$
082c	MO100503	Eastern Region	$50,362		$37,221	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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082d	MO102209	Eastern Region	$142,489		$105,308	$	$	$
087a	MO106598	Northwest Region	$82,836		$42,091	$	$69,271	$
087b	MO903127	Northwest Region	$218,707		$111,129	$	$182,892	$
089a	MO750403	Eastern Region	$439,813		$367,763	$	$	$
090a	MO101136	Eastern Region	$730,143		$677,977	$250,824	$	$
090b	MO101458	Eastern Region	$221,079		$205,284	$75,947	$	$
090c	MO106069	Eastern Region	$76,602		$71,129	$26,315	$	$
090d	MO100381	Eastern Region	$132,357		$122,900	$45,468	$	$
090e	MO102803	Eastern Region	$111,024		$103,092	$38,140	$	$
090f	MO101037	Eastern Region	$7,272		$6,753	$2,498	$	$
090g	MO100765	Eastern Region	$334,527		$310,627	$114,919	$	$
090h	MO100581	Eastern Region	$31,513		$29,262	$10,826	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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090i	MO100786	Eastern Region	$45,088		$41,867	$15,489	$	$
152	X	Eastern Region	$745		$	$	$498,867	$
153b	MO105723	Central Region	$33,551		$51,711	$	$	$
153c	MO000024	Eastern Region	$322,735		$282,512	$	$54,227	$
153d	MO100567	Eastern Region	$352,370		$308,453	$	$59,207	$
153e	MO105715	Eastern Region	$135,183		$118,335	$	$22,714	$
153f	MO105046	Central Region	$87,281		$76,403	$	$14,665	$
153g	MO105780	Central Region	$38,160		$33,404	$	$6,412	$
153h	MO103942	Central Region	$41,408		$36,247	$	$6,957	$
153i	MO101797	Central Region	$3,248		$2,843	$	$546	$
153j	MO105038	Northwest Region	$67,795		$59,345	$	$11,391	$
153k	MO105210	Northwest Region	$67,795		$59,345	$	$11,391	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

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153l	MO101169	Central Region	$310,150		$271,496	$	$52,113	$
153m	MO103892	Northwest Region	$36,130		$31,627	$	$6,071	$
153n	MO103900	Northwest Region	$194,453		$170,218	$	$32,673	$
153o	MO000025	Northwest Region	$145,169		$133,519	$	$	$
153q	MO100668	Central Region	$513,003		$213,034	$	$	$
153r	MO100884	Central Region	$5,683		$4,975	$	$955	$
153s	MO100281	Central Region	$26,793		$23,454	$	$4,502	$
153t	MO100768	Eastern Region	$203,790		$178,391	$	$34,242	$
153u	MO100623	Northwest Region	$101,083		$88,485	$	$16,984	$
153v	MO100714	Northwest Region	$55,210		$48,329	$	$9,277	$
153w	MO106093	Central Region	$14,208		$12,438	$	$2,387	$
154a	MO100526	Northwest Region	$155,134		$124,517	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

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154b	MO301785	Northwest Region	$414,022		$332,312	$	$	$
154c	MO101441	Northwest Region	$260,546		$209,125	$	$	$
154d	MO103678	Northwest Region	$3,315		$2,661	$	$	$
154e	MO100882	Southwest Region	$2,652		$2,129	$	$	$
154f	MO100878	Southwest Region	$8,287		$6,652	$	$	$
154g	MO100615	Southwest Region	$99,113		$79,553	$	$	$
154h	MO100881	Southwest Region	$19,558		$15,698	$	$	$
154i	MO100875	Central Region	$4,972		$3,991	$	$	$
154j	MO100877	Southwest Region	$2,320		$1,862	$	$	$
154k	MO100870	Northwest Region	$72,595		$58,268	$	$	$
154l	MO103900	Northwest Region	$3,646		$2,927	$	$	$
154m	MO100874	Northwest Region	$2,652		$2,129	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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154n	MO106762	Northwest Region	$7,624		$6,119	$	$	$
156b	MO101029	Southwest Region	$234,568		$303,276	$303,276	$	$
156c	MO100287	Southwest Region	$32,922		$42,565	$42,565	$	$
158a	MO000022	Southeast Region	$184,221		$134,116	$	$4,738	$
158b	MO103157	Southeast Region	$33,551		$24,426	$	$863	$
158c	MO902319	Southeast Region	$283,632		$206,489	$	$7,294	$
158d	MO105095	Southeast Region	$78,286		$56,994	$	$2,013	$
158e	MO102571	Southeast Region	$84,499		$61,517	$	$2,173	$
158f	MO106705	Southeast Region	$155,019		$112,856	$	$3,987	$
158g	MO903853	Southeast Region	$309,417		$225,260	$	$7,957	$
158h	MO000021	Southeast Region	$99,722		$72,599	$	$2,565	$
158j	MO103165	Southeast Region	$23,921		$17,415	$	$615	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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158k	MO103140	Southeast Region	$59,336		$43,198	$	$1,526	$
158l	MO100928	Southeast Region	$6,213		$4,523	$	$160	$
158m	MO903259	Southeast Region	$2,175		$1,583	$	$56	$
158n	MO100730	Southeast Region	$63,685		$46,364	$	$1,638	$
171	X	Northwest Region	$16,811		$	$	$240,851	$
173	MO903788	Eastern Region	$479,480		$298,741	$149,467	$	$
174	MO103967	Eastern Region	$59,378		$65,618	$	$	$
175	MO903515	Southwest Region	$		$	$	$	$
183	MO100716	Northwest Region	$		$512,617	$	$	$
185	MO101342	Northwest Region	$3,113		$	$	$99,790	$
188a	MO100922	Southwest Region	$173,017		$82,920	$	$	$
189	MO100591	Eastern Region	$458,288		$425,360	$425,360	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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195	MO101151	Southwest Region	$		$	$	$	$
201a	MO103587	Northwest Region	$1,090,638		$	$	$	$
201b	MO101433	Eastern Region	$359,603		$	$	$	$
207	MO101482	Southwest Region	$67,679		$12,371	$	$	$
208	MO101490	Eastern Region	$204,028		$18,418	$	$	$
209	X	Southwest Region	$83,634		$18,043	$	$	$
210a	MO101623	Eastern Region	$99,605		$18,607	$	$	$
210b	MO103462	Eastern Region	$105,605		$19,727	$	$	$
210c	MO106077	Eastern Region	$77,404		$14,459	$	$	$
210d	MO103884	Eastern Region	$63,003		$11,769	$	$	$
210e	MO100713	Eastern Region	$47,402		$8,855	$	$	$
210f	MO100712	Eastern Region	$81,604		$15,244	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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211	X	Central Region	$92,501		$	$	$	$
216	X	Northwest Region	$11,105		$1,777	$	$	$
217	X	Northwest Region	$57,177		$2,508	$	$	$
219	X	Northwest Region	$		$500	$	$	$
220	X	Central Region	$3,300		$	$	$	$
226	MO101755	Northwest Region	$81,133		$18,583	$	$	$
227	X	Eastern Region	$41,640		$8,039	$	$	$
231	X	Central Region	$98,707		$34,526	$	$	$
238	MO102027	Eastern Region	$57,512		$2,577	$	$	$
239	MO101987	Eastern Region	$41,800		$3,275	$	$	$
249a	MO105434	Southeast Region	$12,202		$839	$	$	$
249b	MO105442	Southeast Region	$5,084		$349	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

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249d	MO102035	Eastern Region	$408,758		$28,094	$	$	$
249e	MO105459	Eastern Region	$32,538		$2,236	$	$	$
249f	MO100738	Southeast Region	$7,118		$489	$	$	$
249g	MO100739	Southeast Region	$8,643		$594	$	$	$
250	MO102050	Northwest Region	$523,145		$61,039	$	$	$
252	X	Southeast Region	$59,666		$14,244	$	$	$
262	MO102928	Eastern Region	$963,245		$119,343	$3,231	$	$
264	X	Southwest Region	$21,573		$5,636	$	$	$
267	X	Statewide (optional)	$		$177,925	$	$873,565	$
269	MO105087	Eastern Region	$		$784,132	$	$	$
274	X	Southwest Region	$35,975		$5,968	$	$	$
275	MO100711	Central Region	$55,236		$2,412	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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276	MO100849	Southwest Region	$390,689		$246,703	$	$	$
277	X	Southeast Region	$15,261		$4,399	$	$	$
282	X	Northwest Region	$19,622		$6,564	$	$	$
287	X	Central Region	$5,205		$1,172	$	$	$
288	X	Southwest Region	$19,938		$3,250	$	$	$
297	X	Northwest Region	$25,987		$	$	$	$
312	MO100622	Southwest Region	$25,306		$28,868	$28,868	$	$
312a	MO903879	Southwest Region	$343,106		$391,394	$391,394	$	$
315	MO100687	Eastern Region	$31,110		$5,759	$	$	$
315a	MO100688	Eastern Region	$36,503		$6,757	$	$	$
316	X	Eastern Region	$6,970		$	$	$	$
318	MO100761	Eastern Region	$		$674,867	$	$	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

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401	X	Statewide (optional)	$		$9,811	$	$	$
402	X	Statewide (optional)	$		$7,222	$	$	$
403	X	Statewide (optional)	$		$21,084	$	$	$
404	X	Statewide (optional)	$		$50,000	$	$	$
405	X	Statewide (optional)	$		$	$	$687,980	$
406	X	Eastern Region	$		$	$	$22,500	$
408	X	Southwest Region	$		$	$	$134,648	$
409	X	Southwest Region	$		$	$	$112	$
411	X	Eastern Region	$		$	$	$60,966	$
412	X	Eastern Region	$		$	$	$103,949	$
413	X	Statewide (optional)	$		$	$	$119,834	$
414	X	Southeast Region	$		$	$	$89,250	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

					FISCAL YEAR 2005			
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416	X	Northwest Region	$		$	$	$268,341	$
417	X	Southeast Region	$8,100		$	$	$51,588	$
418	X	Southeast Region	$6,890		$	$	$66,542	$
419	X	Northwest Region	$		$	$	$4,558	$
420	X	Southwest Region	$34,211		$	$	$207,395	$
421	X	Statewide (optional)	$		$	$	$11,591	$
422	X	Northwest Region	$		$	$	$16,313	$
423	X	Statewide (optional)	$92,957		$	$	$	$
424	X	Southeast Region	$23,162		$	$	$	$
425	X	Northwest Region	$11,390		$	$	$	$
426	X	Eastern Region	$923		$	$	$	$
638	MO100667	Northwest Region	$153,372		$725,884	$	$	$
TOTAL			$28,440,580		$19,752,751	$4,332,091	$5,342,923	$

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

Form 6 Footnotes
Entities without I-SATS IDs are non-treatment programs including prevention programs, traffic offenders education programs, and housing supports. Per Synectics instructions, Missouri has not assigned I-SATS IDs to non-treatment programs.

PROVIDER ADDRESS TABLE

State:
Missouri

Provider ID	Description	Provider Address
008	CENTRAL OFFICE	1706 East Elm Street, Jefferson City, MO, 65101, 5737514942,
152	ST LOUIS AREA NATIONAL COUNCIL	8790 Manchester Road, St Louis, MO, 63144, 3149623456,
171	NATIONAL COUNCIL OF GR KANSAS CITY	633 East 63rd Street, Kansas City, MO, 64110, 8163615900,
209	SAFETY COUNCIL OF THE OZARKS	1111 South Glenstone, Springfield, MO, 65804, 4178692121,
211	AFFILIATED COURT SERVICES	800 North Providence, Ste 104, Columbia, MO, 65201, 5734993784,
216	CAAREC	326 Cherry Street, Chillocothe, MO, 64601, 6606461652,
217	CENTRAL STATES MENTAL HEALTH CON	3217 South Owens School Road, Independence, MO, 64057, 8162244417,
219	COUNTY COURT SERVICES	PO Box 32267, Kansas City, MO, 64171, 8164742121,
220	"RASSE	78 West Arrow Street, PO Box 38, Marshall, MO, 65340, 6608863373,
227	SAFETY COUNCIL OF GREATER STL	1015 Locust Street, Suite 902, St Louis, MO, 63101, 3146219200,
231	TRAFFIC SAFETY AWARENESS	PO Box 575, Linn Creek, MO, 65052, 5733463829,
252	ACCREDITED TRAFFIC OFFENDER SERV	1515 East Mqalone, Sikeston, MO, 63801, 5734717710,
264	DOOR TO HOPE	1714 Camp Clark Hill, Galena, MO, 65656-0015, 4173576263,
267	ACT MO	428 East Capital Avenue, Second Floor, Jefferson City, MO, 65101, 5736356669,
274	ALCOHOL DRUG CONSULTANTS	1736 East Sunshine, Ste 214, Springfield, MO, 65804, 4178484565,
277	HEARTLAND ALTERNATIVE SERVICE PROG	101 Oak Street, Poplar Bluff, MO, 63901, 5736865488,
282	ST JOSEPH SAFETY & HEALTH COUNCIL	118 South Fifth Street (Lower LEvel), St Jospeh, MO, 64501-2130, 8162333330,
287	DEAF HOPE	PO Box 14441, Shawnee Missions, KS, 66215, 9132814875,
288	SOUTH CENTRAL MO CITIZEN'S ADVISORY	1015 Lanton Road, West Plains, MO, 65775, 4172562570,
297	ABOUT FACE COMMUNITY COUNSELING	6301 Rockhill Road, Suite 105, Kansas City, MO, 64131, 8164446200,

Provider ID	Description	Provider Address
316	"JONES	309 West 4th Street, Suite 101, Washington, MO, 63090,
401	"COMMUNITY HOUSING NETWORK	2600 East 12th Street, Kansas City, MO, 64127, 8164825744,
402	COVINGTON AND BURLING	1201 Pennsylvania Avenue, NW, Washington, DC, 20044, 2026625410,
403	"OXFORD HOUSE	1010 Wayne Avenue, Suite 400, Silver Spring, MD, 20910,
404	UNIVERSITY OF MO - KC	5100 Rockhill Road, Kansas City, MO, 64110, 8162352647,
405	UNIVERSITY OF MO - COLUMBIA	Sponsored Programs Admin 310 Jesse, Columbia, MO, 65211, 5738829587,
406	BIG BROTHERS BIG SISTERS	4625 Lindell, Suite 501, St Louis, MO, 63108, 3143615900,
408	COMMUNITY PARTNERSHIP OF OZARKS	330 North Jefferson, Springfield, MO, 65806, 4178637700,
409	COUNTY OF GRENE PROSECUTING ATTY	1010 Boonville Ave, Springfield, MO, 65802, 4178684061,
411	DISCOVERING OPTIONS	909 Purdue Avenue, St Louis, MO, 63130, 3147218116,
412	FRIENDS WITH A BETTER PLAN	5622 Delmar Suite 102E, St Louis, MO, 63112, 3143612371,
413	"LEAD INSTITUTE	311 Bernadette Drive, Suite C, Columbia, MO, 65203, 5734455005,
414	LINCOLN UNIVERSITY	Business & Finance, 306 Young Hall, Jefferson City, MO, 65102, 5736815058,
416	MO ALLIANCE OF BOYS/GIRLS CLUB	6301 Rockhill Road, Suite 303, Springfield, MO, 64131, 8163613600,
417	PREVENTION CONSULTANTS OF MO	104 East 7th Street, Rolla, MO, 65401, 5733684755,
418	SOUTHEAST MO STATE UNIVERSITY	One University Plaza, Cape Girardeau, MO, 63701, 5736512196,
419	ST JOSEPH POLICE DEPARTMENT	501 Faraon, St Joseph, MO, 64501, 8162714701,
420	UNITED WAY OF THE OZARKS	320 North Jefferson, Springfield, MO, 65806-1109, 4178637700,
421	UNIVERSITY OF OKLAHOMA	Office of Proj & Conpl Ass. 660 Parring, Norman, OK, 73019, 9186603700,
422	CITY OF INDEPENDENCE POLICE CHIEF	223 North Memorial Drive, Independence, MO, 64050, 8163257291,

Provider ID	Description	Provider Address
423	SAVE	PO Box 45301, Kansas City, MO, 64171, 8165318340,
424	CORRECTIONAL COUNSELING INC	1071 Jones Street, Kennett, MO, 63857, 5738886233,
425	JOHN SUTHERLAND COUNSLEING LLC	902 Edmond Street, Suite 210, St Joseph, MO, 64501-2762, 8162335343,
426	MISSOURI VALLEY ADP	1175 Cave Springs Estates, St Peters, MO, 63376, 636419002,

Prevention Strategy Report

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Mentors [15]	3
	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Pregnant Women/Teens [2]	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Drop-Outs [3]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Media campaigns [3]	3
	Information lines/Hot lines [8]	1
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	0
	Drug free dances and parties [21]	2
	Community service activities [24]	12
	Recreation activities [26]	5
	Student Assistance Programs [32]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
Violent and Delinquent Behavior [4]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	2
	Community service activities [24]	12
	Recreation activities [26]	5

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Violent and Delinquent Behavior [4]	Driving while under the influence/driving while intoxicated education programs [33]	12
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Accessing services and funding [45]	12
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	12
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Economically Disadvantaged [6]	Resources directories [2]	16

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	2
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Systematic planning [42]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Physically Disabled [7]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	0
	Brochures [4]	2
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	1

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Physically Disabled [7]	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Abuse Victims [8]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Already Using Substances [9]	Resources directories [2]	16
	Media campaigns [3]	2

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Already Using Substances [9]	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	5
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Community service activities [24]	2
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	16
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Media campaigns [3]	0
	Brochures [4]	22
	Radio and TV public service announcements [5]	1

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Homeless and/or Run away Youth [10]	Information lines/Hot lines [8]	1

TREATMENT UTILIZATION MATRIX

State:
Missouri

Dates of State Expenditure Period:
From 7/1/2005 to 6/30/2006 (Same as Form 1)

			Costs Per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons Served**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24 hour Care)					
1. Hospital Inpatient			**$.00**	**$.00**	**$.00**
2. Free-standing Residential	**8,564**	**6,088**	**$305.69**	**$250.20**	**$143.31**
Rehabilitation / Residential					
3. Hospital Inpatient			**$.00**	**$.00**	**$.00**
4. Short-term (up to 30 days)	**10,590**	**8,422**	**$275.06**	**$300.00**	**$105.90**
5. Long-term (over 30 days)			**$.00**	**$.00**	**$.00**
Ambulatory (Outpatient)					
6. Outpatient	**25,080**	**24,518**	**$756.85**	**$422.50**	**$179.92**
7. Intensive Outpatient	**16,259**	**12,788**	**$2,543.07**	**$1,558.60**	**$337.60**
8. Detoxification			**$.00**	**$.00**	**$.00**
9. Opioid Replacement Therapy	**497**	**456**	**$1,571.45**	**$1,337.66**	**$82.37**

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

Form 7b

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:
Missouri

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

AGE GROUP	A. TOTAL	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	3,739	1,554	1,002	655	343	4		1		3	10	51	34	49	33	2,237	1,385	80	37
2. 18-24	7,345	4,043	1,679	1,092	301	8	4	7	1	17	13	27	12	107	34	5,150	1,990	151	54
3. 25-44	21,298	10,467	5,127	3,602	1,577	29	8	15	5	57	35	29	14	253	80	14,104	6,722	348	124
4. 45-64	7,624	3,777	1,316	1,808	590	3	1	6	2	32	14	2	4	59	10	5,563	1,919	124	18
5. 65 and over	183	93	36	46	5								1	2		137	42	4	
6. Total	40,189	19,934	9,160	7,203	2,816	44	13	29	8	109	72	109	65	470	157	27,191	12,058	707	233
7. Pregnant Women	497		352		125		1				5		4		10		485		12

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers?

☒ **Yes** ☐ **No**

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period: 8,744

Missouri

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

TB SERVICES

The Division of Alcohol and Drug Abuse (ADA) works in cooperation with the Missouri Department of Corrections, Missouri Department of Health and Senior Services, and the Missouri Department of Social Services, Division of Medical Services, to collect the information required to report the statewide non-federal cost of tuberculosis services provided for citizens of Missouri, as well as to the substance abusers in treatment in Missouri. The statewide expenditures for tuberculosis services to substance abusers in treatment have been calculated with the following methodology.

The Department of Corrections provides aggregated costs of TB services to inmates in correctional facilities and associated costs to those inmates in institutional substance abuse treatment programs.

The Department of Health and Senior Services provides aggregated costs of the number of clients treated for TB by local health departments. In addition, non-federal costs of the TB tests performed at local health departments is computed for clients referred from ADA funded treatment programs.

The Department of Social Services provides statewide expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management Information System. The State Medicaid expenditures for TB treatment provided by ADA funded programs per the Department of Mental Health Purchase of Service (POS) system are a subset of the information received from Medical Services and represent the percent of expenditures that were spent on substance abusers in treatment.

The final component of the TB cost determination is from the Department of Mental Health Purchase of Service (POS) system which captures services delivered to clients by service code. The payments for these non-Medicaid TB services were summed and segregated by funding source (Non-Federal or State Funds) per the POS data system.

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

The Division used the following method to calculate the amounts for the base and subsequent years for services to pregnant women and women with dependent children. The Department of Mental Health Purchase of Service (POS) system captures services delivered to clients by service code. For the base year 1992, all payments for services to women at programs meeting the requirements of Section 1922© and Section 96.124 (e) were summed and segregated by funding source (Federal Block Grant and Non-Federal or State Funds). The total expenditures on these qualified programs were $10,686,147 for FFY2006 and projected to be $10,473,353 for FFY2007. These amounts are greater than the required base expenditures of $7,728,020. The Division estimates FFY2008 level of expenditures based on the services provided during FFY2007 increased by the 4% Cost of Living Adjustment funded during the SFY2008 budget process.

State:
Missouri

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2005) + B2(2006) / 2 (C)
SFY 2005 (1)	$37,041,952	
SFY 2006 (2)	$38,930,686	$37,986,319
SFY 2007 (3)	$42,488,213	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2005 ☒ **Yes** ☐ **No**

FY 2006 ☒ **Yes** ☐ **No**

FY 2007 ☒ **Yes** ☐ **No**

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2007 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ **Yes** ☒ **No** **If yes, specify the amount and the State fiscal year:** $0 | 0

Did the State include these funds in previous year MOE calculations? ☐ **Yes** ☒ **No**

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

TB (MOE Table II)

State:
Missouri

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	$421,670	.06%	$253	
SFY 1992 (2)	$455,117	.5%	$2,276	$1,264

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2007 (3)	$547,961	9.433044%	$51,689

HIV (MOE Table III)

State:
Missouri

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B)
SFY1993 (1)	$298,242	
SFY1994 (2)	$304,625	$301,434

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2007 (3)	$0

*** Provided to substance abusers at the site at which they receive substance abuse treatment**

HIV (MOE Table III) Footnotes
Missouri is not a designated state.

Womens (MOE TABLE IV)

State:
Missouri

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	$7,728,020	
2005		$9,553,405
2006		$10,686,147
2007		$10,473,353

Enter the amount the State plans to expend in FY 2008 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $10,892,287

Womens (MOE TABLE IV) Footnotes
During the July 17, 2007 Southwest Region Webinar states were advised as the reference to 'State Fiscal Years' was removed from the form instructions, it now reads "Report expenditures for 2005, 2006, and 2007 in column B," and states could report on the FFY or SFY. Missouri is reporting on FFY 2006.

Missouri

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F. R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Those States that have a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, must describe its composition and its contribution to needs assessment, planning, and evaluation processes for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- 42 U.S.C. 300x-51 and 45 C.F. R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2008 application for SAPT Block Grant funds.

Substate Area Planning

The Missouri Department of Mental Health has five planning regions that are used by its Division of Alcohol and Drug Abuse (ADA) and Division of Comprehensive Psychiatric Services (CPS). The ADA planning regions are further divided into service areas consisting of clusters of counties. The largest metropolitan service areas comprise one or two counties while some of the rural service areas cover up to nine counties. In June 2000, ADA completed a planning process that culminated in the goal of providing a full array of substance abuse services in each of ADA's 20 Service Areas. Since then, decisions regarding the placement of new or expanded services have generally been based on prioritizing the treatment or prevention needs of each service area and then identifying the un-served or under-served areas with the greatest unmet need. To support planning and allocation at this geographic level, needs assessment data is captured by service area whenever possible.

For several years, the State Treatment Needs Assessment Program (STNAP) has provided estimates of substance abuse treatment need. The STNAP-I household report was finalized in 1997 and the estimates were supplemented in 1999 for non-household populations. Based on a broader household survey and a jail inmate study completed for the STNAP-II project, updated treatment needs estimates were compiled for the report *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*. The new study provided estimates for adolescents as well as adults and for each Service Area.

The STNAP data was utilized in determining the service areas that would be targeted for primary recovery treatment expansion under the Access to Recovery CSAT grant. The focus was to identify the service areas of the state most in need of new or additional services for adult women, based on rankings of criteria and changes in rankings from 2000. Data from the STNAP-II were used in formulating two of the five criteria -- the number of women needing treatment and the percent needing treatment who are pregnant. A third criterion was treatment penetration rates of ADA's adult female target population. Rather than defining target population using the STNAP-II estimates of the number who would seek treatment, ADA used data from the 2003 National Survey of Substance Abuse Treatment Services (N-SSATS), which found 80.8% of Missouri treatment consumers received services in non-profit programs that utilize state and federal funds. That percentage was applied to the STNAP-II treatment needs estimates to determine the number who would need to access publicly supported treatment programs administered by ADA. The other two criteria used for ranking service area need for women's services dealt with Medicaid eligible births and availability of Medicaid eligible services.

Prevention planning and identification of highest need are ongoing processes. Data collection has evolved from solely qualitative community-based information to more comprehensive methods. The process has expanded the CSAP Prevention Needs Assessment Studies and has incorporated new data from other resources. Two of the Prevention Needs Assessment Studies, the Missouri Student Survey and the Social

Indicator Study, have been utilized at the local level by coalitions for identifying needs and requesting DMH funding for local level mini-grants and other federal and private sources of funding for strategies and programming. The studies were also part of the identification process for the five pilot sites of the School-based Prevention and Intervention Initiative (SPIRIT). Information for risk and prevalence data is captured through both qualitative and quantitative methods. Additionally, as a pilot state for CSAP's MIS project, ADA's service providers are required to input service process information into the Minimum Data Set (MDS-3) server. The MDS-3 project collects service type, target audience, aggregate demographics of participants, and risk factors. Since the initial replication of the Missouri Student Survey in 2002, subsequent prevention initiatives have used a variety of methods and different levels of substate data collection. ADA initiatives and programs have provided the following information: specific K-12 school data and research-based program monitoring of SPIRIT; training needs of the prevention workforce, the Prevention Works: the Next Step research project (Pentz and Hawkins); localized underage drinking information from the OJJDP EUDL discretionary awards; and binge drinking rates among college students from the CORE survey.

The one-year CSAP State Incentive Planning Grant and the five-year Strategic Prevention Framework State Incentive Grant (SPF SIG) are making a significant contribution to planning through the formation of the Governor's Substance Abuse Prevention Initiative Advisory Committee. Building on the work and information from the CSAP Prevention Needs Assessment Studies completed in the early part of the decade, the Advisory Committee and its workgroups have completed or are currently developing several projects. They conducted Hispanic and Asian focus groups in each of the state's planning regions, piloted the Tri-Ethnic Institute's Community Readiness Assessment, developed an inventory of prevention resources and activities, and prepared a prevention needs assessment report. The Prevention Workforce Development Task Force was created in order to assess workforce activities and training needs and make recommendations regarding standardized training and multi-tier certification program. They have developed a Missouri Prevention Workforce Survey Report.

As a requirement of the SPF SIG, a State Epidemiology Workgroup (SEW) was established in April 2005. Membership of the SEW consists primarily of data managers and researchers in government agencies that address substance abuse problems. These include the U.S. Drug Enforcement Administration, Missouri State Highway Patrol, Missouri Department of Health and Senior Services, Missouri Department of Corrections, Missouri Department of Social Services, Missouri Department of Mental Health, St. Louis Mental Health Board, and St. Louis Community Epidemiology Work Group. The SEW assembled and compared rates of Missouri and national substance abuse consumption and consequences data, including all data sets contained in the State Epidemiology Data System (SEDS). The SEW also used county-level Missouri data in a geographic information system to map the number of occurrences, and population-based rates of a variety of substance abuse consequences. These included alcohol and drug related traffic crashes, arrests, emergency room episodes, juvenile

court referrals, out-of-home placements, and births compromised by maternal substance abuse. This data analysis, recommendations, and a comprehensive *SPF SIG Initial Needs Assessment* report developed by project staff at the Missouri Institute of Mental Health were presented to the Governor's Advisory Committee. The Advisory Committee considered several substance abuse problems identified as priority issues and adopted a state prevention plan that addresses risky drinking behavior, including underage and binge alcohol use in the 12-25 age group. The State Strategic Plan has been submitted to CSAP and approved for implementation. County-level data are not available in Missouri on underage and binge alcohol use, so the SEW will assist the prevention coalitions funded through the SPF SIG to develop data sources that can be used to measure the effectiveness of the funded projects in reducing rates of risky drinking. The SEW will also continue to monitor and compare national, state, and county data to support ongoing project planning, feedback to funded coalitions, and data-driven outcome evaluation.

Technological advances are also part of the evolving system. ADA strives to achieve more effective and efficient ways for risk, incidence, prevalence, and highest need identification. Such progress is evident with the improvements made in capturing student information. In 2000, the first Missouri Student Survey was administered to a random sample of 12,600 students in 254 schools. In 2002, the survey was replicated using state specific lessons learned and a larger sample. The 2004 Missouri Student Survey was the first to be administered over the Internet using the SmartTrack application and was made available to all of Missouri's 524 school districts. Although not all districts were able to participate, approximately 60,000 students in grades 6–12 participated in the survey. With almost 70,000 participants, the 2006 Missouri Student Survey is the largest of its type in the state.

Planning culminates with its integration into the state budgeting process. Treatment and prevention program performance and outcome measures are described and quantified in the annual budget requests of the Department of Mental Health and its divisions, including ADA. Measured performance is annually compared with projections, and new or revised decision items with plan components are developed to address emerging needs. During the processes of prioritizing and justifying these proposed programs and services, additional plan details such as consumer eligibility, treatment methods, program locations, and management issues are clarified and elaborated.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by state and is an advisory body to ADA and the ADA director. The SAC is comprised of 25 members appointed by the director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services, and no more than one-fourth can be ADA treatment or prevention vendors. The SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs

to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current technologies and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system, and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding. The SAC has input into the SAPT BG and has an opportunity to provide feedback as does the general public as the annual SAPT BG applications are posted on the ADA website found at: http://www.dmh.missouri.gov/ada/blockgrant.htm. Five Regional Advisory Councils (RACs), representing the five ADA planning regions, work with the SAC to identify and study local needs. The ADA Prevention Office provides the administrative and logistic support for the SAC and all of the RACs.

The SAC and RACs consult with ADA's District Administrators, Area treatment Coordinators, and prevention specialists. The treatment coordinators monitor the ADA-funded treatment programs and their utilization rates and refer prospective consumers to programs which are the most appropriate, accessible, and available. The Prevention Specialists monitor ADA-funded prevention programs and provide consultation on appropriate strategies. The District Administrators gather input from their staffs, the advisory council members, and other sources to develop a thorough understanding of the service gaps in their districts with regard to locations, types of services, and populations to be served. The ADA Executive Staff utilize data from the needs assessment models and consult with the District Administrators on decisions involving program expansions and reallocations. Information from these multiple sources helps ensure that ADA expends its funds to provide services in communities and for populations with the greatest needs.

The Governor's Substance Abuse Prevention Initiative Advisory Committee provides an additional advisory body. With representation from state agencies impacted by substance abuse, other stakeholders, the SAC and RAC, and service providers, and with technical support from its subcommittees and the State Epidemiological Workgroup, the Advisory Committee will have an important role in making allocation recommendations to ADA.

Public Comment in Plan Development

The Missouri Advisory Council on Alcohol and Drug Abuse, commonly referred to as the State Advisory Council (SAC), and its network of five Regional Advisory Councils (RACs) constitutes the formal mechanism that ensures that Missouri citizens have an opportunity to participate in and express their views regarding the state's publicly funded substance abuse prevention and treatment system managed by the Missouri Division of Alcohol and Drug Abuse (ADA). The SAC's statutory mandate is to collaborate with ADA to disseminate public information about alcohol and drug abuse; review current social technologies and recommend improvements to substance abuse prevention and treatment programs based upon scientific evidence; recommend what should be changed--and how--to improve and update the substance abuse service delivery system; and participate in developing standards for prevention and treatment services.

The State Advisory Council has 25 members consisting of service providers, consumers (recipients of services or family members of recipients), and other interested citizens. The Council meets regularly and holds conference calls to receive updates from ADA staff and provide feedback on budget-related matters, legislative initiatives, strategic planning and performance measurement development, and other aspects of the service delivery system. The Council appoints ad hoc committees as needed to address priority issues and make recommendations to ADA. Each Regional Advisory Council (RAC) meets periodically and encourages discussion and analysis of local prevention and treatment issues, seeking input from individuals, agencies, and organizations involved in or impacted by substance abuse. Some RAC members also have roles as members of community-based prevention teams and coalitions, comprised of volunteers who provide leadership in substance abuse prevention, intervention, and policy development. The RAC chairpersons attend the regular meetings of the SAC and work with the SAC on various projects.

The content of the SAPT block grant application reflects recommendations generated through this citizen input. The compressed time frame for preparing the SAPT application precludes a full review by the advisory council network prior to its submission to the Center for Substance Abuse Treatment. To facilitate ongoing review, each application is posted to the ADA website at http://www.dmh.missouri.gov/ada/blockgrant.htm. ADA notifies the SAC and RAC members of the application submission, encourages them and their constituents to review it, and asks them to communicate their comments to ADA's central and district office staff for consideration in developing the next application. This process provides for ongoing access to the SAPT applications and feedback from the advisory network and the general public.

State:
Missouri

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2008 block grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

3 Population levels, Specify formula:
2005 population estimates of service areas

3 Incidence and prevalence levels

4 Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

5 Problem levels as estimated by social indicator data

5 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specific method)
maintance of existing services

2 Size of gaps between resources (as measured by)
number of consumers served in FY 2007

and needs (as estimated by)
updated prevalence estimates based on the Missouri 2004/2005 NSDUH

_ Other (specify):

Planning Checklist Footnotes
Funds generally appropriated to priorities 1, 2 and 3. If additional funds are obtained, priorities 4 and 5 would have funds appropriated to them.

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Missouri	0

		3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating While Intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Northwest Region	1,405,689	83,309	1,795	2,963	1,628	26,367	868	8,858	12,500	43	9	1	3

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating While Intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Central Region	766,523	82,262	6,578	1,604	674	24,515	1,923	5,866	4,852	236	5	4	1

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating While Intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Eastern Region	2,068,218	200,579	13,814	4,321	2,284	61,610	4,577	9,851	14,277	10	8	3	3

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating While Intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Southwest Region	866,691	59,258	811	1,851	604	19,729	683	6,121	5,617	49	15	1	2

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Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Missouri	0

		3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating While Intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Southeast Region	**693,180**	**59,592**	**1,139**	**1,481**	**562**	**18,928**	**826**	**4,855**	**5,125**	**9**	**8**	**2**	**1**

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating While Intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
State Total	**5,800,310**	**485,000**	**24,137**	**12,220**	**5,753**	**151,149**	**8,878**	**35,551**	**42,371**	**346**	**46**	**11**	**10**

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

Form 8 Footnotes
Summed age group figures may not reflect the reported total due to rounding.

Figures in Column 2 are U.S. Census estimates for 2005. Figures in Columns 3, 4, and 5 originated in a table formatted to match Form 8 published in the report titled "Integrating
Population
Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update", RTI International, September 2003. The estimates were most recently updated by the Division of Alcohol and Drug Abuse in 2007 based on 1) population changes between Census 2000 (the population applied to the 2003 RTI prevalence rates) and the 2005 population estimates; and 2) prevalence rate changes in Missouri since 2003 based on the combined Missouri samples from the 2004/2005 National Survey on Drug Use and Health using the state estimates for number of residents with "alcohol or drug illicit dependence or abuse." See also "How your State determined the numbers for the matrix" [Q:\Block Grant applications\FFY 2008 Block Grant] for the methodology.

Treatment Needs by Age, Sex, and Race/Ethnicity

State:	Substate Planning Area [95]:
Missouri	State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	47,999	27,742	14,865	3,262	1,328	0	0	33	0	38	100	192	182	175	82	30,397	16,032	1,045	525
2. 18 - 24	140,876	83,416	36,874	12,596	5,531	11	15	196	118	254	221	380	192	807	265	95,489	42,169	2,171	1,047
3. 25 - 44	197,082	115,303	51,392	19,801	8,625	31	8	310	66	361	231	138	61	550	205	133,432	59,558	3,062	1,030
4. 45 - 64	75,346	43,800	19,877	7,683	3,547	4	0	48	23	136	75	7	14	99	33	50,748	23,339	1,029	230
5. 65 and over	23,697	14,091	6,161	2,387	952	0	0	0	0	0	0	0	106	0	0	16,163	7,090	315	129
6. Total	485,000	284,352	129,169	45,729	19,983	46	23	587	207	789	627	717	555	1,631	585	326,229	148,188	7,622	2,961

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

Form 9 Footnotes
Summed age group figures may not reflect the reported total due to rounding.

Figures in Column 2 are U.S. Census estimates for 2005. Figures in Columns 3, 4, and 5 originated in a table formatted to match Form 8 published in the report titled "Integrating
Population
Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update", RTI International, September 2003. The estimates were most recently updated by the Division of Alcohol and Drug
Abuse in 2007 based on 1) population changes between Census 2000 (the population applied to the 2003 RTI prevalence rates) and the 2005 population estimates; 2) prevalence rate changes in Missouri since 2003 based on the combined Missouri samples from the 2004/2005 National Survey on Drug Use and Health using the state estimates for number of residents with "alcohol or illicit drug dependence or abuse;" and, 3) proportions of clients served in ADA treatment programs in FY 2006 by race and Hispanic origin. See also "How your State determined the numbers for the matrix" [Q:\Block Grant applications\FFY 2008 Block Grant] for the
methodology.

Missouri

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

How your State determined the numbers for the matrix

Form 8:

Column 1: Substate planning area
The Division of Alcohol and Drug Abuse (ADA) configures Missouri into five large planning regions, each consisting of clusters of counties referred to as service areas. Missouri's three largest cities anchor three of these regions. Kansas City is located in the Northwest Region, St. Louis is in the Eastern Region, and Springfield is in the Southwest Region. Columbia, the fifth largest city, is in the Central Region. Cape Girardeau is the largest city in the Southeast Region.

Column 2: Total population
The population of each sub-state region listed on Form 8 is based on the 2005 population estimates prepared by the U.S. Census Bureau and the Missouri Census Data Center.

Column 3: Total population in need
Prevalence estimates in column 3A reflect updates to the Missouri State Treatment Needs Assessment Program (STNAP-II) study. ADA prepared the updates in 2007 based on changes in the Missouri population that occurred between 2000 (the study's population base) and 2005. Adjustments were made for county-level population changes by age and gender. The updates also encompass Missouri estimates prepared by SAMHSA's Office of Applied Studies (OAS). The OAS estimates are derived from the Missouri samples from the National Survey on Drug Use and Health (NSDUH) for 2004 and 2005. Treatment need by age group is based on the OAS estimate of individuals with "alcohol or illicit drug dependence or abuse." The aggregate treatment need of 485,000 for Missouri should be a valid approximation because it is generally consistent with the STNAP-II estimate of 491,224 produced in the 2003 study. Total treatment need is disaggregated according to the OAS estimates for the age groups of 12-17, 18-25 (adjusted to 18-24), and 26 and older (adjusted for 25-44, 45-64, and 65 and over). Components of these estimates for ADA planning region, gender and race/ethnicity ("white" and "other") are based on the STNAP-II rates.

Column 3B provides updated estimates of the number who would seek treatment but are currently not receiving services. The updates utilize the treatment seeking rates for each service area from the STNAP-II study applied to the updated treatment need estimates for each service area aggregated to the planning regions. The updated total number who would seek treatment is 78,126. In FY 2006, ADA provided substance abuse treatment services to 53,989 Missouri residents whose county of residence (and therefore ADA planning region) are known. By subtracting the residents who accessed treatment services from the 78,126 who would seek treatment, an estimated 24,137 residents who would seek substance abuse treatment did not receive services in FY 2006. This unmet demand is reported by planning region in column 3B.

Column 4: Number of IVDUs in need

Prevalence estimates for Missouri's population in need of treatment for intravenous drug use was updated based on changes in the Missouri population that occurred between 2000 and 2005. The estimated 12,377 intravenous drug users (IVDU) from the STNAP-II study was updated to 12,220 and all of these individuals need treatment. Although the STNAP-II study did not estimate the number of IVDU who would seek treatment, it did estimate that 50% of high-risk non-household adults would seek treatment. During the last three years, ADA has actually provided services to more than 50% of the estimated IVDU in some of the planning regions, so a potential treatment seeking rate of 75% of prevalence was applied to the IVDU to yield an estimated 9,165 IVDU that would seek treatment. Subtracting the 3,412 IVDU whose county of residence (and therefore ADA planning region) are known and who received treatment services in FY 2006 from the 9,165 who would seek services, an estimated 5,753 IVDU who would seek treatment did not receive services in FY 2006. This unmet demand is reported by planning region in column 4B.

Column 5: Number of women in need

The prevalence estimates totaling 144,665 women in column 5A are a subset of the updated treatment need estimates provided in column 3A and reflect changes in the female population of each county between 2000 and 2005. Column 5B provides updated estimates of the number of women who would seek treatment but are currently not receiving services. The updates utilize the female treatment seeking rates for each service area from the STNAP-II study applied to the updated female treatment need estimates for each service area aggregated to the planning regions. The updated total number of women who would seek treatment is 24,159. In FY 2006, ADA provided substance abuse treatment services to 16,453 Missouri women whose county of residence (and therefore ADA planning region) are known. By subtracting the women who accessed treatment services from the 25,178 who would seek treatment, an estimated 8,725 women have an unmet demand for treatment. This unmet demand is reported by planning region in column 5B.

Limitation of Data in Columns 3, 4, and 5

The STNAP-II study was conducted from 2000 to 2003. The household telephone interviews, which provided much of the core data for the prevalence estimates, were administered in 2001 and 2002, so much of the data is five years old or older. Although the aggregate treatment need of 491,224 identified by the STNAP-II is very close to the estimate of 485,000 with alcohol or illicit drug dependence or abuse derived from the 2004-2005 NSDUH, components of the NSDUH estimates are very different. STNAP-II estimated that 39,000 adolescents needed substance abuse treatment or intervention, including 29,378 who needed treatment. OAS estimated that 48,000 adolescents have alcohol or illicit drug dependence or abuse. There were also variances in the other age groups between the STNAP-II treatment need estimates and the dependence and abuse estimates from the NSDUH.

ADA will review the latest NSDUH estimates for Missouri and its planning regions as they become available and will integrate these survey results into the Missouri

prevalence estimates. The sub-state data should provide more clarification on the geographic distribution of Missouri's population in need of substance abuse treatment services.

Column 6: Prevalence of substance-related criminal activity
DWI arrests, drug arrests, and boating while intoxicated (BWI) arrests are included in the Uniform Crime Reporting system. Data is coded according to the county of arrest and aggregated to the ADA planning regions. BWI was selected for reporting in the optional column because Missouri has a large number of lakes and navigable streams that are used for boating, skiing, canoeing, and other water recreation. Alcohol-related boat crashes, drowning, and injuries are a significant problem in the state.

Column 7: Incidence of communicable diseases
The 2005 data on acute and chronic hepatitis B, HIV&AIDS, and tuberculosis disease were provided by the Missouri Department of Health and Senior Services. The data are aggregated to the ADA planning regions using the county of residence at time of diagnosis. The rates are based on the number of cases per 100,000 residents in accordance with 2005 population estimates.

Form 9:

As noted above in the explanation for Form 8 column 3A, rates from the 2003 STNAP-II report were used to disaggregate the NSDUH estimate of 485,000 Missouri residents with alcohol or illicit drug dependence or abuse, the figure used as a proxy for substance abuse treatment need. The STNAP-II study provided estimates of treatment need for only two population groups--"White Non-Hispanic" and "Other". Data for Form 9 column A (485,000) matches the total in Form 8, column 3A. Data for Form 9 column B is based on the STNAP-II estimates for "White Non-Hispanic" with the adjustments described above for Form 8, column 3. Data for Form 9 columns C, D, E, F, G, and H use the proportions of non-Caucasian clients served in ADA treatment programs in FY 2006 applied to the adjusted non-white treatment need derived from the STNAP-II study. Data for Form 9 columns I and J are estimates based on the proportion of Hispanic and non-Hispanic clients served in ADA treatment programs in FY 2006.

Form 11

State:
Missouri

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

SOURCE OF FUNDS

(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2008 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$19,544,616	$48,141,186	$17,453,182	$54,791,646	$172,488	$0
2. Primary Prevention	$5,215,917		$5,546,578	$663,062	$0	$0
3. Tuberculosis Services	$15,073	$15,380	$0	$35,054	$0	$0
4. HIV Early Intervention Services	$0	$97,028	$0	$1,391,400	$0	$0
5. Administration (excluding program/provider level)	$1,303,979		$150,000	$2,730,470	$187,512	$0
6. Column Total	$26,079,585	$48,253,594	$23,149,760	$59,611,632	$360,000	$

Form 11ab

State:
Missouri

Form 11a: Primary Prevention Planned Expenditures Checklist

	Block Grant FY 2008	Other Federal	State	Local	Other
Information Dissemination	**$590,797**	**$1,012,336**	**$11,854**	**$**	**$**
Education	**$2,198,852**	**$1,045,146**	**$20,574**	**$**	**$**
Alternatives	**$192,281**	**$979,240**	**$24**	**$**	**$**
Problem Identification & Referral	**$3,489**	**$**	**$**	**$**	**$**
Community-Based Process	**$763,666**	**$**	**$13,276**	**$**	**$**
Environmental	**$832,368**	**$1,660,910**	**$528**	**$**	**$**
Other	**$274,149**	**$848,946**	**$**	**$**	**$**
Section 1926 - Tobacco	**$360,315**	**$**	**$616,806**	**$**	**$**
TOTAL	**$5,215,917**	**$5,546,578**	**$663,062**	**$**	**$**

Form 11b: Primary Prevention Planned Expenditures Checklist

	Block Grant FY 2008	Other Federal	State	Local	Other
Universal Direct	**$1,369,030**	**$5,219,944**	**$663,062**	**$**	**$**
Universal Indirect	**$2,337,490**	**$**	**$**	**$**	**$**
Selective	**$1,509,397**	**$326,634**	**$**	**$**	**$**
Indicated	**$**	**$**	**$**	**$**	**$**
TOTAL	**$5,215,917**	**$5,546,578**	**$663,062**	**$**	**$**

Form 11ab Footnotes
Other Federal: Safe and Drug Free Schools & Communities; Strategic Prevention Framework State Incentive Grant (SPF SIG)

State: General Revenue; Healthy Family Trust (State Tobacco Settlement Funds)

Form 11c

State:
Missouri

Resource Development Planned Expenditure Checklist

Does your State plan to fund resource development activities with FY 2008 funds?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$300,000**	**$**	**$300,000**
Quality Assurance	**$**	**$**	**$**	**$**
Training (post-employment)	**$42,500**	**$7,500**	**$**	**$50,000**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$26,667**	**$184,226**	**$**	**$210,893**
Research and Evaluation	**$66,500**	**$333,074**	**$**	**$399,574**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$135,667**	**$824,800**	**$**	**$960,467**

Form 12

State:
Missouri

TREATMENT CAPACITY MATRIX

This form contains data covering a 24-month projection for the period during which your principal agency of the State is permitted to spend the FY 2008 block grant award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient		
2. Free-standing Residential	**17,128**	**12,176**
Rehabilitation / Residential		
3. Hospital Inpatient		
4. Short-term (up to 30 days)	**21,180**	**16,844**
5. Long-term (over to 30 days)		
Ambulatory (Outpatient)		
6. Outpatient	**50,160**	**49,036**
7. Intensive Outpatient	**32,518**	**25,576**
8. Detoxification		
9. Opioid Replacement Therapy	**994**	**912**

OMB No. 0930-0080 Approved: 09/20/2007 Expires: 09/30/2010

State:
Missouri

Purchasing Services

Methods for Purchasing This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2008 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐	Competitive grants	Percent of Expense: %
☒	Competitive contracts	Percent of Expense: 99%
☐	Non-competitive grants	Percent of Expense: %
☒	Non-competitive contracts	Percent of Expense: 1%
☐	Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐	Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐	According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐	Line item program budget		Percent of Clients Served: % Percent of Expenditures: %
☐	Price per slot		Percent of Clients Served: % Percent of Expenditures: %
	Rate:	Type of slot:	
	Rate:	Type of slot:	
	Rate:	Type of slot:	
☒	Price per unit of service		Percent of Clients Served: 100% Percent of Expenditures: 100%
	Unit: hour		Rate: 48.3
	Unit: hour		Rate: 9.1
	Unit: hour		Rate: 6

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Program Performance Monitoring

☒ On-site inspections

(Frequency for treatment:) annually

(Frequency for prevention:) annually

☒ Activity Reports

(Frequency for treatment:) monthly

(Frequency for prevention:) monthly

☒ Management information System

☒ Patient/participant data reporting system

(Frequency for treatment:) monthly

(Frequency for prevention:) monthly

☒ Performance Contracts

☒ Cost reports

☒ Independent Peer Review

☒ Licensure standards - programs and facilities

(Frequency for treatment:) every three years

(Frequency for prevention:) every three years

☒ Licensure standards - personnel

(Frequency for treatment:) every three years

(Frequency for prevention:) every three years

☐ Other (Specify):

Form T1 was pre-populated with the following Data Source: Discharges in CY 2006

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]	**1,886**	**1,753**
Total number of clients with non-missing values on employment status [denominator]	**8,404**	**8,404**
Percent of clients employed (full-time and part-time) or student	**22.4%**	**20.9%**
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$] **-1.5%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**8,012**
Number of CY 2006 discharges submitted:	**8,800**
Number of CY 2006 discharges linked to an admission:	**8,743**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**8,669**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**8,404**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]		
Total number of clients with non-missing values on employment status [denominator]		
Percent of clients employed (full-time and part-time) or student		
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Intensive Outpatient (IO)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]	**1,738**	**1,940**
Total number of clients with non-missing values on employment status [denominator]	**9,295**	**9,295**
Percent of clients employed (full-time and part-time) or student	**18.7%**	**20.9%**
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$] **2.2%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**12,407**
Number of CY 2006 discharges submitted:	**9,868**
Number of CY 2006 discharges linked to an admission:	**9,839**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**9,666**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**9,295**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Outpatient (OP)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]	**5,989**	**6,567**
Total number of clients with non-missing values on employment status [denominator]	**12,600**	**12,600**
Percent of clients employed (full-time and part-time) or student	**47.5%**	**52.1%**
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$] **4.6%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**17,093**
Number of CY 2006 discharges submitted:	**14,382**
Number of CY 2006 discharges linked to an admission:	**14,297**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**13,689**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**12,600**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Form T2 was pre-populated with the following Data Source: Discharges in CY 2006

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]	**4,705**	**4,761**
Total number of clients with non-missing values on living arrangements [denominator]	**5,287**	**5,287**
Percent of clients with stable housing	**89.0%**	**90.1%**
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$] **1.1%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**8,012**
Number of CY 2006 discharges submitted:	**8,800**
Number of CY 2006 discharges linked to an admission:	**8,743**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**8,669**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**5,287**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]		
Total number of clients with non-missing values on living arrangements [denominator]		
Percent of clients with stable housing		
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Intensive Outpatient (IO)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]	**2,829**	**2,850**
Total number of clients with non-missing values on living arrangements [denominator]	**3,151**	**3,151**
Percent of clients with stable housing	**89.8%**	**90.4%**
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$] **0.6%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**12,407**
Number of CY 2006 discharges submitted:	**9,868**
Number of CY 2006 discharges linked to an admission:	**9,839**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**9,666**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**3,151**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Outpatient (OP)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]	**3,031**	**3,056**
Total number of clients with non-missing values on living arrangements [denominator]	**3,151**	**3,151**
Percent of clients with stable housing	**96.2%**	**97.0%**
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$] **0.8%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**17,093**
Number of CY 2006 discharges submitted:	**14,382**
Number of CY 2006 discharges linked to an admission:	**14,297**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**13,689**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**3,151**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Form T2 Footnotes
Missouri does not have long-term residential services.

Form T3 was pre-populated with the following Data Source: Discharges in CY 2006

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

Short-term Residential(SR)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]	**4,521**	**4,793**
Total number of clients with non-missing values on arrests [denominator]	**5,382**	**5,382**
Percent of clients with no arrests	**84.0%**	**89.1%**
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$] **5.1%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**8,012**
Number of CY 2006 discharges submitted:	**8,800**
Number of CY 2006 discharges linked to an admission:	**8,743**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**8,721**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**5,382**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Intensive Outpatient (IO)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]	**3,029**	**3,111**
Total number of clients with non-missing values on arrests [denominator]	**3,477**	**3,477**
Percent of clients with no arrests	**87.1%**	**89.5%**
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$] **2.4%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**12,407**
Number of CY 2006 discharges submitted:	**9,868**
Number of CY 2006 discharges linked to an admission:	**9,839**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**9,816**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**3,477**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Outpatient (OP)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]	**2,799**	**2,749**
Total number of clients with non-missing values on arrests [denominator]	**3,091**	**3,091**
Percent of clients with no arrests	**90.6%**	**88.9%**
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$] **-1.7%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**17,093**
Number of CY 2006 discharges submitted:	**14,382**
Number of CY 2006 discharges linked to an admission:	**14,297**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**14,229**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**3,091**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Form T3 Footnotes
Missouri does not have long-term residential services.

Form T4 was pre-populated with the following Data Source: Discharges in CY 2006

ALCOHOL ABSTINENCE

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol [numerator]	**4,347**	**5,643**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**8,225**	**8,225**
Percent of clients abstinent from alcohol	**52.9%**	**68.6%**
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$] **15.7%**	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**1,430**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**3,878**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**36.9%**

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**4,213**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**4,347**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**96.9%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**8,012**
Number of CY 2006 discharges submitted:	**8,800**
Number of CY 2006 discharges linked to an admission:	

	8,743
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**8,721**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**8,225**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from alcohol		
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$]	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol [numerator]	**6,315**	**7,255**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**9,152**	**9,152**
Percent of clients abstinent from alcohol	**69.0%**	**79.3%**
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$] **10.3%**	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**1,192**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**2,837**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**42.0%**

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**6,063**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**6,315**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**96.0%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**12,407**
Number of CY 2006 discharges submitted:	**9,868**
Number of CY 2006 discharges linked to an admission:	**9,839**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**9,816**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**9,152**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol [numerator]	**10,425**	**11,612**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**13,824**	**13,824**
Percent of clients abstinent from alcohol	**75.4%**	**84.0%**
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$] **8.6%**	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**1,646**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**3,399**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**48.4%**

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**9,966**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**10,425**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**95.6%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**17,093**
Number of CY 2006 discharges submitted:	**14,382**
Number of CY 2006 discharges linked to an admission:	**14,297**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**14,229**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**13,824**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Form T4 Footnotes
Missouri does not have long-term residential services.

Form T5 was pre-populated with the following Data Source: Discharges in CY 2006

DRUG ABSTINENCE

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from drugs [numerator]	**2,428**	**4,086**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**8,225**	**8,225**
Percent of clients abstinent from drugs	**29.5%**	**49.7%**
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$] **20.2%**	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**1,779**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**5,797**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**30.7%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**2,307**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**2,428**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**95.0%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**8,012**
Number of CY 2006 discharges submitted:	**8,800**
Number of CY 2006 discharges linked to an admission:	

	8,743
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**8,721**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**8,225**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from drugs		
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$]	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]	**3,360**	**5,269**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**9,152**	**9,152**
Percent of clients abstinent from drugs	**36.7%**	**57.6%**
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$] **20.9%**	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**2,212**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**5,792**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**38.2%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**3,057**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**3,360**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**91.0%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**12,407**
Number of CY 2006 discharges submitted:	**9,868**
Number of CY 2006 discharges linked to an admission:	**9,839**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**9,816**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**9,152**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]	**9,265**	**10,616**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**13,824**	**13,824**
Percent of clients abstinent from drugs	**67.0%**	**76.8%**
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$] **9.8%**	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**2,010**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**4,559**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**44.1%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**8,606**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**9,265**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**92.9%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**17,093**
Number of CY 2006 discharges submitted:	**14,382**
Number of CY 2006 discharges linked to an admission:	**14,297**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**14,229**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**13,824**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Form T5 Footnotes
Missouri does not have long-term residential services.

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Social Support of Recovery

GOAL To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported participation in one or more social and or recovery support activity at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported participation in one or more social and recovery support activities at discharge equals clients reporting participation at admission subtracted from clients reporting participation at discharge.

Most recent year for which data are available	From: 1/1/2006	To: 12/31/2006

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	3,070	5,693
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	7,955	7,955
Percent of clients participating in social support activities	**38.59%**	**71.57%**
Percent of clients participating in social support of recovery activities in prior 30 days at discharge minus percent of clients participating in social support of recovery activities in prior 30 days at admission. (Positive percent change values indicate increased participation in social support of recovery activities.)	Absolute Change [$\%T_2$-$\%T_1$] **32.97% / 85.44%**	

State Description of Employment Status Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described** **During CY 2006, Missouri underwent an information system change. The data that was cross-walked from the old system to the new in terms of self-help groups included "referral" which artificially inflated the number receiving social supports. As a result, Missouri used GPRA data for this measure. GPRAs were not required for all clients. Therefore, the total number of admissions and discharges are low but we anticipate future years will be significantly higher.**

DATA SOURCE	**What is the source of data for table T6? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source

	☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T6? (Select one)** ◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T6? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☑ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T6? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ◉ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing social support of recovery data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 1/1/2006	To: 12/31/2006

Length of Stay			
Level of Care	**Average**	**Median**	**Standard Deviation**
Detoxification (24-Hour Care)			
1. Hospital Inpatient	0	0	0
2. Free-standing Residential	0	0	0
Rehabilitation / Residential			
3. Hospital Inpatient	0	0	0
4. Short-term (up to 30 days)	23.09	21	22.43
5. Long-term (over 30 days)	0	0	0
Ambulatory (Outpatient)			
6. Outpatient	83.7	62	85.08
7. Intensive Outpatient	79.33	39	127.75
8. Detoxification	5.49	4	18.65
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement Therapy	0	0	0
10. ORT Outpatient (optional)	489.47	372	581.46

Missouri

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Authority capacity and capability to make data driven decisions based on performance measures? Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

Treatment Performance Measures

The Department of Mental Health, Division of Alcohol and Drug Abuse, as the Single State Authority (SSA) has used data-driven decisions based on a limited number of performance measures in the past. Effective October 1, 2006 the SSA implemented a new Customer Information Management, Outcomes, and Reporting System (CIMOR).

The CIMOR system, when fully operational, will provide a wealth of information to assist in data driven decisions based on performance measures.
The system includes:

- all consumer demographic information.
- assessment information.
- TEDS data and GPRA data.
- services provided including date of service, number of units, and amount billed by funding source.

Business rules are included in the system design. These business rules include contract limitations, standard (provider certification) requirements, and requirements for timeframes for data entry and updates.

Barriers to successful implementation of the CIMOR system to enhance data driven decisions include:

- provider indifference about entering data.

  Resolution:
  Information has been presented to providers about the need for timely and accurate information entry in CIMOR.

- CIMOR implementation. As with any new system of this size, there have been many challenges. The Division continues to correct design errors and errors in business rules. Many of the errors in business rules impacted the ability of the providers to be paid. One of those rules needing correction tied payment to a provider's entry of TEDS and GPRA data. A design error resulted in data being overlaid instead of keeping historical information. As a result, some business rules were removed from the system so that providers could be paid.

  Resolution:
  The SSA provided the Office of Information Technology (ITSD) with prioritized design and rule corrections. The Office of ITSD is responsible for correcting the system to meet the needs of the SSA. A large number of the rule corrections and design changes will be completed during the fall of 2007.

The Division of Alcohol and Drug Abuse (ADA) produces a variety of regular and ad hoc reports. Several reports are compiled on an annual basis including: Alcohol, Drug and Tobacco Use in Missouri; Status Report on Missouri's Alcohol and Drug Abuse

Problems; School-based Prevention Intervention and Resources Initiative (SPIRIT); Compulsive Gambling; Block Grant, and Synar. The Missouri Student Survey is produced in even-numbered years and monitors the risk behaviors of middle and high school students in public schools in the state. All of these are available on line at http://www.dmh.missouri.gov/ada/adaindex.htm or http://www.missouriprevention.org/. Reports for providers such as client discharge, GPRA, and GAIN compliance have been provided on a monthly basis. These reports are posted to an FTP site for providers to access. In the future the Division anticipates these and other provider reports will become available on demand with the capability to define reporting period, service type, etc., via the Customer Information Management, Outcomes, and Reporting (CIMOR) system. ADA responds to frequent data requests from legislators, providers, media, and the public. These ad hoc reports are generally emailed to the individual requestor, but can result in distribution internally or externally.

To date ADA has not set benchmarks but is anticipating implementation of a provider scorecard in the coming year that will enable ADA to redirect unspent funds to those providers meeting the identified targets. ADA expects providers to improve performance.

Missouri has not developed evidence-based practices (EBP's) or programs however ADA incorporated EBP's in all treatment and prevention programs.

At this time, ADA does not have a regular training program for provider staff nor a workforce development plan but is in the discussion phase of both.

The Division of ADA requires providers to supply information about the intensity and numbers of services provided to consumers via the CIMOR system.

Form P1

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–17 - FFY 2005 (Baseline)	21.40	
		Ages 18+ - FFY 2005 (Baseline)	50.80	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]	Ages 12–17 - FFY 2005 (Baseline)	17.50	
		Ages 18+ - FFY 2005 (Baseline)	33.10	
3. 30-day Use of Other Tobacco Product	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days,	Ages 12–17 - FFY 2005 (Baseline)	10.30	
		Ages 18+ - FFY 2005 (Baseline)	12.20	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2005 (Baseline)	8	
		Ages 18+ - FFY 2005 (Baseline)	5.20	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - FFY 2005 (Baseline)	6.30	
		Ages 18+ - FFY 2005 (Baseline)	3.30	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form Footnotes:

Form P2

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	75.90	
		Ages 18+ - FFY 2005 (Baseline)	77.60	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	93.70	
		Ages 18+ - FFY 2005 (Baseline)	93.70	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	85.70	
		Ages 18+ - FFY 2005 (Baseline)	75.70	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P3

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2005 (Baseline)	12.90	
		Ages 18+ - FFY 2005 (Baseline)	17.10	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 12–17 - FFY 2005 (Baseline)	11.90	
		Ages 18+ - FFY 2005 (Baseline)	15.50	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2005 (Baseline)	13	
		Ages 18+ - FFY 2005 (Baseline)	18.90	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2005 (Baseline)	13.50	
		Ages 18+ - FFY 2005 (Baseline)	18.20	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2005 (Baseline)	12.80	
		Ages 18+ - FFY 2005 (Baseline)	21.50	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	85.20	
2. Perception of Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2005 (Baseline)	82.60	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	81.50	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	82.10	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	85.20	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P5

NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 15–17 - FFY 2005 (Baseline)	23.40	
		Ages 18+ - FFY 2005 (Baseline)	43.60	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P7

NOMs Domain: Employment/Education

Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2005 (Baseline)	94	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P8

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2005 (Baseline)	41	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P9

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2005 (Baseline)	130	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P10

NOMs Domain: Social Connectedness

Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2005 (Baseline)	57.60	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2005 (Baseline)	98.10	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

NOMs Domain: Retention

Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2005 (Baseline)	93	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12A

Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Missouri used the MDS to collect NOMs data.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Race is recorded through the MDS. Data was collected for each applicable race category.

Category	Description	Total Served
A. Age	1. 0-4	20
	2. 5-11	2006
	3. 12-14	909
	4. 15-17	660
	5. 18-20	457
	6. 21-24	729
	7.25-44	2748
	8. 45-64	1082
	9. 65 And Over	42
	10. Age Not Known	
B. Gender	Male	5027
	Female	4562
	Gender Unknown	
	White	6117
	Black or African American	4002

C. Race	Native Hawaiian/Other Pacific Islander	18
	Asian	80
	American indian/Alaska Native	6
	Race Unknown or Other (not OMB required)	
D. Ethnicity	Hispanic or Latino	119
	Not Hispanic or Latino	2618

Form P12B

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	468
	2. 5-11	22226
	3. 12-14	16363
	4. 15-17	8847
	5. 18-20	2125
	6. 21-24	2923
	7.25-44	27872
	8. 45-64	20820
	9. 65 And Over	7056
	10. Age Not Known	
B. Gender	Male	49973
	Female	58727
	Gender Unknown	
C. Race	White	75776
	Black or African American	29025
	Native Hawaiian/Other Pacific Islander	444
	Asian	660
	American indian/Alaska Native	320
	Race Unknown or Other (not OMB required)	

	Hispanic or Latino	2143
	Not Hispanic or Latino	41606

Form P13

Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	74871	N/A
2. Universal Indirect	N/A	291401
3. Selective	9589	N/A
4. Indicated	67	N/A
5. Total	84527	291401

Form P14

Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
  - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
  - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). "Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
Missouri uses the Strategic Prevention Framework process to implement the three guidelines. The process includes: assessment of the community needs and readiness; capacity building to mobilize and address the needs of the community; development of a prevention plan to identify the activities, programs, and strategies necessary to address the needs; implementation of the prevention plan; and, evaluation of the results to achieve sustainability and cultural competency.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Missouri utilized the Minimum Data Set to collect data. During 2005, providers experienced multiple errors when entering data. Therefore, not all providers entered data. Missouri requested technical assistance from the CSAP MDS contractor as system errors occurred.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	14	17	31	19	1	51
2. Total number of Programs and Strategies Funded	14	17	31	19	1	51
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Form P15

Services Provided Within Cost Bands

Type of Intervention	A. Number of Programs and Strategies	B. Number of Programs and Strategies Falling Within Cost Bands	C. Percent of Programs and Strategies Falling Within Cost Bands
1. Universal Direct Programs and Strategies	14	12	86 %
2. Universal Indirect Programs and Strategies	17	17	100 %
3. Subtotal Universal Programs	31	29	93.55%
4. Selective Programs and Strategies	19	19	100 %
5. Indicated Programs and Strategies	1	1	100 %
6. Total All Programs	51	49	96.08%

Form P15 Footnotes
Missouri utilized the Minimum Data Set to collect SAPT BG 2005 compliance data. During 2005, providers experienced multiple errors when entering data for Universal Direct (UD) and Indicated Programs (I). Missouri requested technical assistance (TA) from the CSAP MDS contractor as system errors occurred. However, the State was unable to correct all the data errors for UD and I programs, due to the aforementioned technical difficulties with Minimum Data Set and staff turnover within the UD providers.

Because of these technical errors and staff turnover, for FFY 2008 cost-band reporting, Missouri is unable to determine an accurate cost per participant for those UD and I programs that were impacted by data entry errors and staff turnover.

Currently, the error in the system has been identified and corrected. UD services staff have been provided with alternative data collection procedures of required information until they are trained to enter data into MO’s Minimum Data Set. Beginning July 1, 2008, 2006 data will be available for future cost-band reporting of Universal Direct and Indicated Programs.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D:
2005 Block Grant Subrecipient Cost Band Worksheet

Subrecipient Name:_____

Date Form Completed:_____

Name of Contact Person:_____

Phone:_____ **E-mail Address:**_____

Table 1: Progam Detail

1	2	3	4	5	6
Program Name	**Number of Participants**	**Number of Program Hours Received**	**Total Cost of the Program**	**Average Cost Per Participant (Col 4/Col 2)**	**Average Cost Per Participant Falls Within 2005 Cost Bands (Yes=1 No=0)**
Universal Direct Programs					**Universal Direct: $58.01–$693.98**
1.					
2.					
3.					
4.					
Universal Indirect Programs					**Universal Indirect $1.05–$82.26**
1.					
2.					
3.					
4.					
Selective Programs					**Selective $151.88–$6,409.29**
1.					
2.					
3.					
4.					
Indicated Programs					**Indicated $510.47–$4,888.44**
1.					
2.					
3.					
4.					

Table 2: Subrecipient Cost Band Summary

	1	2
Program Type	**Number of Programs**	**Number of Programs Falling Within Cost Bands**
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Total		

Instructions for Completing the 2005 Block Grant Subrecipient Cost Band Worksheet

The 2005 Block Grant Subrecipient Cost Band Worksheet is an optional tool that States may use for their providers to record the number of program participants, the number of hours received, the cost of each program, the average cost per program participant, and the number of programs whose average participant costs fall within the 2005 cost bands. Data should be based on total cost of program not only the funding from CSAP. States may use an alternative approach to obtain data used to report the aggregate cost band data in Form P15 of the SAPT Block Grant Application. These worksheets are not required as part of that submission.

1. Subrecipient Information

Grant Information. At the top of the page, enter the name of the subrecipient, the contact information for the person completing this form, and the date on which the form was completed.

2. Table 1: Program Detail

Column 1: Program Name. In column 1, list the names of all programs that were funded in whole or in part with Block Grant funds during Federal fiscal year (FY) 2005. Add additional rows if necessary.

A program is defined as an activity, a strategy, or an approach intended to prevent an outcome or to alter the course of an existing condition. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance use or substance abuse-related risk factors.

Separate table sections are provided for programs that are defined as Universal Direct, Universal Indirect, Selective, and indicated. Universal indirect services are defined as services that support prevention activities, such as population-based activities, and the provision of information and technical assistance. Universal direct, selective, and indicated services are defined as prevention program interventions that directly serve participants.

- ***Universal.*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
    - ***Universal Direct.*** Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
    - ***Universal Indirect***. Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- ***Selective.*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- ***Indicated.*** Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Column 2: Number of Participants. In this column, specify the number of participants who took part in the preventive program during FY 2005. If this intervention was delivered to multiple groups, combine all groups and report the total. If it is an indirect program, use the estimated number of people reached during the reporting year.

Column 3: Number of Program Hours Received. In this column, report the number of hours that program participants received over the course of the program.

Column 4: Total Cost of This Program. In this column, report the total of all costs expended on the program during the reporting year. This should include all costs associated with the program, such as staff training, staff time, and materials, during the year.

Column 5: Average Cost Per Participant. Report the average cost per participant. Calculate the average cost by dividing the Block Grant dollars expended on each program (column 4) by the number of participant s served (column 2).

Column 6: Average Cost Per Participant Falls Within Cost Bands. Compare the average cost per participant (column 5) with the 2005 cost bands for each program type. If the average cost per participant falls within the specified interval, record a "1" in column 5. If the average cost is either higher or lower than the cost band interval, enter a zero in column 5.

3. Table 2: Subrecipient Cost Band Summary

Table 2 summarizes information recorded in Table 1.

Column 1: Number of Programs. In column 1, enter the total number of programs on which you reported in Table 1, by program types (Universal Direct, Universal Indirect, Selective, and Indicated). Total the number of programs in the last row.

Column 2: Number of Programs Falling Within Cost Bands. For each program type, enter the total number of programs that fell within the cost bands for that program type (i.e., programs that were coded "1" in Table 1, column 5).

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Missouri

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)
No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.